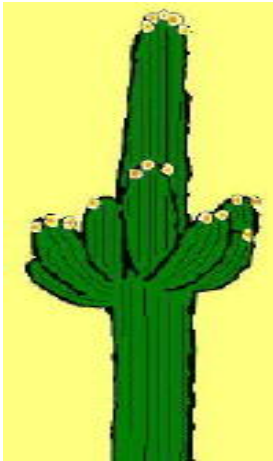


ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

OVERVIEW



October 1, 2003
through
September 30, 2004

Director: Anthony D. Rodgers

AHCCCS MISSION

Reaching across Arizona to provide
comprehensive, quality health care for
those in need

AHCCCS VISION

Shaping tomorrow's managed
healthcare.....from today's experience,
quality and innovation

AHCCCS CUSTOMER

Depending on the changing role of AHCCCS we
recognize different internal and external
customers, but we have only one fundamental
focus that inspires our efforts:
**OUR PRIMARY CUSTOMERS ARE AHCCCS
MEMBERS**

AHCCCS OVERVIEW 2004

TABLE OF CONTENTS

CHAPTER 1

Beginnings and Future of AHCCCS.....1

CHAPTER 2

Acute Care Program.....4

CHAPTER 3

Arizona Long Term Care System.....9

CHAPTER 4

KidsCare Program.....14

CHAPTER 5

Administrative Features and Regulatory Controls
in a Managed Care System.....16

CHAPTER 6

Evaluations of the AHCCCS Program.....28

APPENDICES

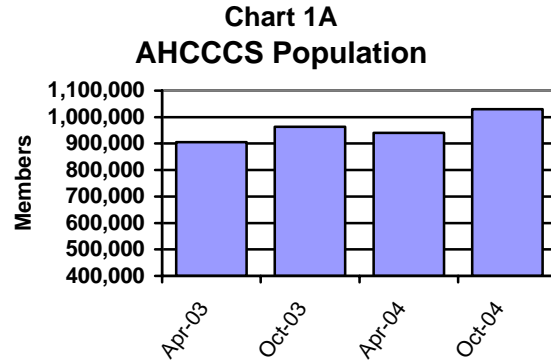
APPENDIX I	AHCCCS Eligibility Requirements
APPENDIX II	AHCCCS Enrollment (1982 to 2004)
APPENDIX III	AHCCCS Covered Services
APPENDIX IV	Expenditures for Federal fiscal year 2004
APPENDIX V	Snapshots of Year One through Year Twenty-Two

AHCCCS does not discriminate on the basis of disability in admission to, access to or operations of its programs, activities, services, or in its employment practices. Individuals with disabilities, who need accommodations, including auxiliary aids or services for effective communication or additional information can contact the AHCCCS ADA coordinator at (602) 417-4014. This document is available in alternate formats by contacting (602) 417-4534.

CHAPTER 1 OVERVIEW OF AHCCCS

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program. As of October 1, 2004, AHCCCS was providing health care coverage to over 1,030,000 members, which is approximately 18 percent of Arizona's total population (see Chart 1A). The growth of this program comes on the heels of both a recession and an expansion of eligibility to 100% of the federal poverty level for most of the covered populations.

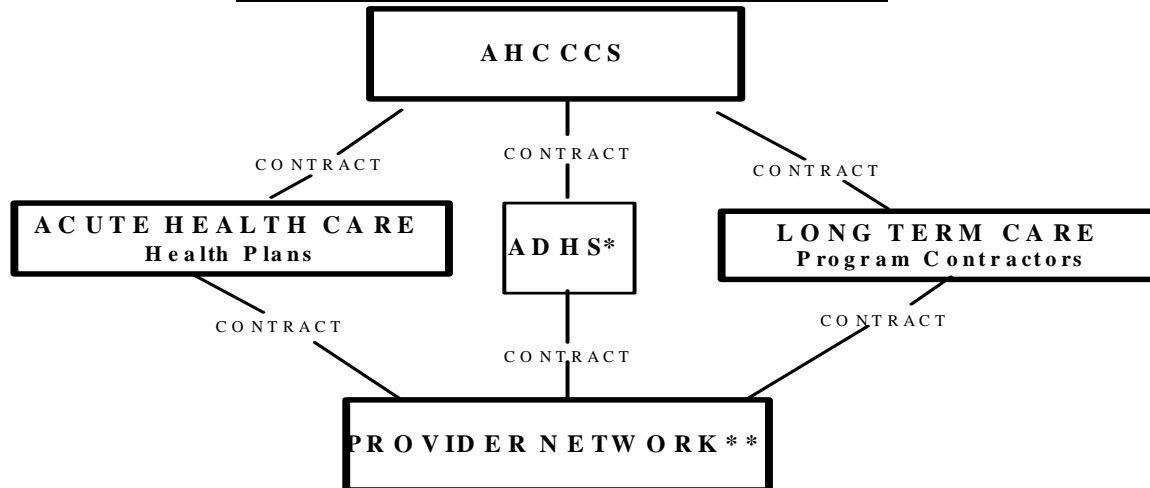
AHCCCS has operated under an 1115 Research and Demonstration Waiver since 1982 when the original waiver was granted by the Centers for Medicare and Medicaid Services (CMS). During that period, a number of waiver extensions have been approved by CMS. AHCCCS currently has a five-year extension that will expire on September 30, 2006, at which time AHCCCS will negotiate an extension of the waiver with CMS. The only way that the current AHCCCS waiver can be made permanent is with a change to federal law.



AHCCCS was created to defray the cost of indigent health care. Prior to 1982, Arizona was the only state in the nation that had declined federal Medicaid funds for low-income women, children, aged, blind, and the disabled. Rather than accepting federal funds for health care, the state had a disjointed system of indigent health care provided by individual counties as it saw fit and could afford. In 1980, the counties turned to the Arizona legislature for help. The legislature responded and passed legislation in 1981 that created the Arizona Health Care Cost Containment System (AHCCCS). On October 1, 1982, AHCCCS became the first statewide Medicaid managed care system in the nation.

AHCCCS was created as a partnership between the state and private and public managed care Health Plans that mainstreamed Medicaid recipients into private physician offices. This arrangement opened up the private physician network to Medicaid recipients and allowed AHCCCS members to choose a Health Plan and a primary care provider, who acted as gatekeeper for the system and managed all aspects of medical care for a member. AHCCCS Health Plans are paid an upfront, or prospective, monthly capitation amount for each member enrolled with the Health Plan. This capitated concept, although new to Medicaid in 1982, was patterned on the way many consumers paid for private health care insurance. AHCCCS has a competitive bid process and regulatory oversight by the agency that includes operational and financial reviews of the Health Plans and contract monitoring to ensure quality of care.

Chart 1B
EXISTING AHCCCS MODEL



*Behavioral Health services for acute care members are provided through the ADHS contract by Regional Behavioral Health Authorities and by Program Contractors for ALTCS members. **Almost all Health Plans and Program Contractors provide dental services on a fee-for-service basis.

The start-up of the program on October 1, 1982, only 11 months from the time legislation was approved, was too short. The state contracted with a private administrator, McAuto Systems Group Inc. They were unable to establish a provider network, provide adequate regulatory oversight, develop a uniform accounting system or maintain a computer system that was capable of supporting managed care. Reimbursement was inadequate and many providers left the system. The turnaround began slowly in 1984 after the state ended the contract with McAuto and Governor Babbitt created a cabinet-level agency reporting directly to him.

From the beginning, AHCCCS has operated under an 1115 Research and Demonstration waiver granted by Health and Human Services. Under that waiver, the state can operate a statewide, managed care system and require all enrollees to enroll in a contracted Health Plan. After AHCCCS stabilized, the Arizona Legislature added long term care benefits through the Arizona Long Term Care System (ALTCS). The ALTCS program has been touted as a model for the nation mainly for its reliance on community based placements and support services in lieu of institutional care for the elderly, physically disabled or developmentally disabled populations. Unique among the states, ALTCS bundles all long term care services into a package (acute, behavioral health, case management, home and community-based services and institutional care) that is coordinated by various Program Contractors under contract with AHCCCS in all counties in the state. Like the acute care program, AHCCCS reimburses Program Contractors with a capitation payment for each enrolled member.

AHCCCS has undergone many changes since 1990. In 1991, the first managed care computer system in the nation was brought on-line after several years of intense effort. The system requires continual modifications to keep pace with the demands and eventually will need to be replaced.

In addition to the major system changes, AHCCCS has implemented many new programs and initiatives in the past seven years.

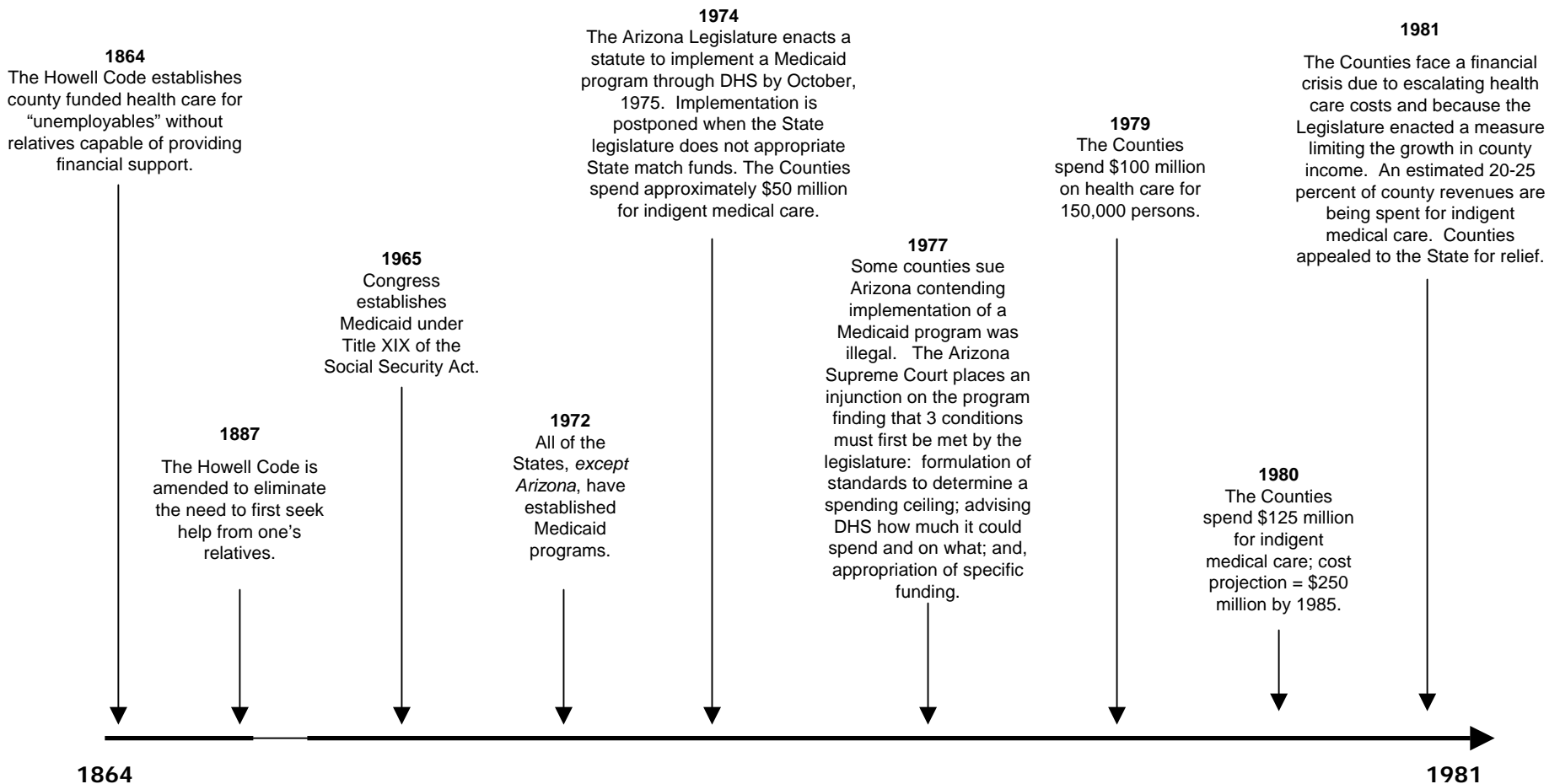
- In 1995, AHCCCS completed a five-year phase-in of behavioral health care services for the Medicaid program. In contrast to the long-term care program, behavioral health services for the acute care population are carved-out and delivered through an Intergovernmental Agreement between AHCCCS and the Arizona Department of Health Services (ADHS). ADHS contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal RBHAs to deliver behavioral health services to members.

- In 1995, AHCCCS launched a major quality improvement initiative designed to test new ways to measure quality of care in a managed care environment.
- In 1998, AHCCCS implemented the State Children's' Health Insurance Program (KidsCare) with federal funding of 75 percent for uninsured children.
- In November 2000, Arizona voters approved Proposition 204, which expanded income limits to 100 percent of the Federal Poverty Level (FPL) and added over 88,000 new people to the AHCCCS rolls in 18 months.
- In January of 2003, parents of KidsCare and Medicaid enrolled children with income between 100 percent and 200 percent FPL became eligible under a HIFA II waiver.

AHCCCS has evolved into a mature and well-respected health care system. Many independent studies have praised the program. In fact, in 2002, the Nelson A. Rockefeller Institute of Government called AHCCCS a "smashing success" and cited Arizona as the "gold standard" for the nation as a model purchaser of health care services.

Exhibit 1

Health Care in Arizona before AHCCCS



Arizona's AHCCCS Years

1981

On November 18, Governor Bruce Babbitt signed into law Senate Bill 1001, which establishes AHCCCS as a program within DHS. AHCCCS is authorized to deliver prepaid capitated health care statewide to Title XIX eligible persons and State-funded indigent persons. AHCCCS operates as a prepaid, capitated managed care demonstration project under Medicaid.

1982

In May, DHS contracts with McDonnell Douglas Automation System Group, Inc. (McAuto) to administer the AHCCCS program.

1982

Three year demonstration waiver is approved by the Centers for Medicare and Medicaid Services (CMS) enabling the implementation of the AHCCCS acute care program on October 1, 1982.

1984

AHCCCS becomes an independent State agency (previously a Division of the Department of Health Services).

1984

Arizona terminates the McAuto contract and takes over the administration of AHCCCS on March 16.

1985

AHCCCS demonstration waiver extended by CMS for two additional years through September 30, 1987.

1987

Waiver request includes proposal for Arizona Long Term Care System (ALTCS). ALTCS proposal is approved by CMS which also approves demonstration waiver for an additional year.

1988

Beginning January 1, 1988, small employers in four counties are allowed to purchase medical coverage for their employees from AHCCCS Health Plans through Healthcare Group. AHCCCS receives CMS approval of waiver through September 30, 1993 (5 years).

1988

ALTCS program implemented on December 19, 1988 for the developmentally disabled and January 1, 1989 for the elderly or physically disabled.

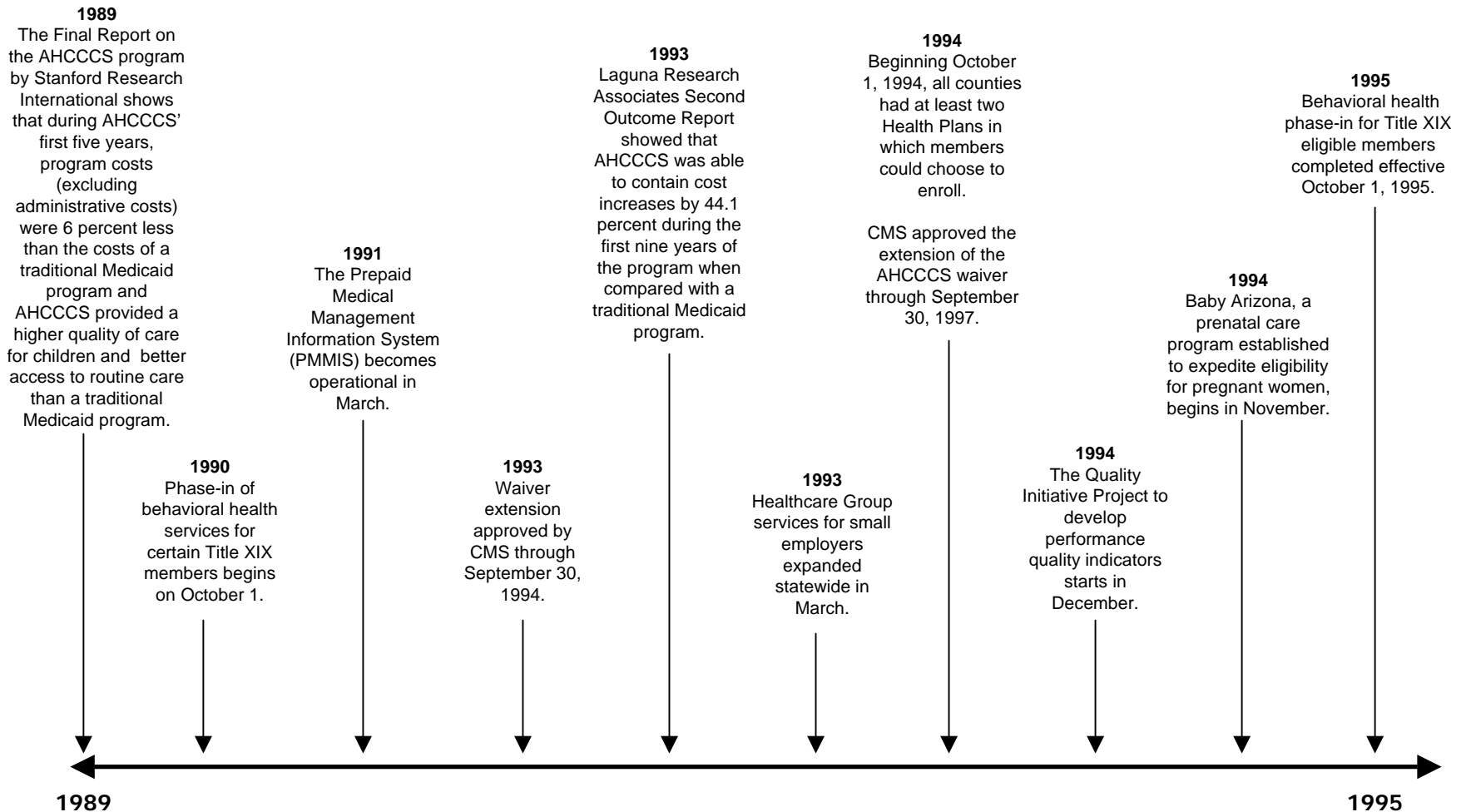
1989

A survey commissioned by the Flinn Foundation showed that the overwhelming majority of AHCCCS members were completely satisfied with the program and that only 5 percent of members were dissatisfied with the care they received.

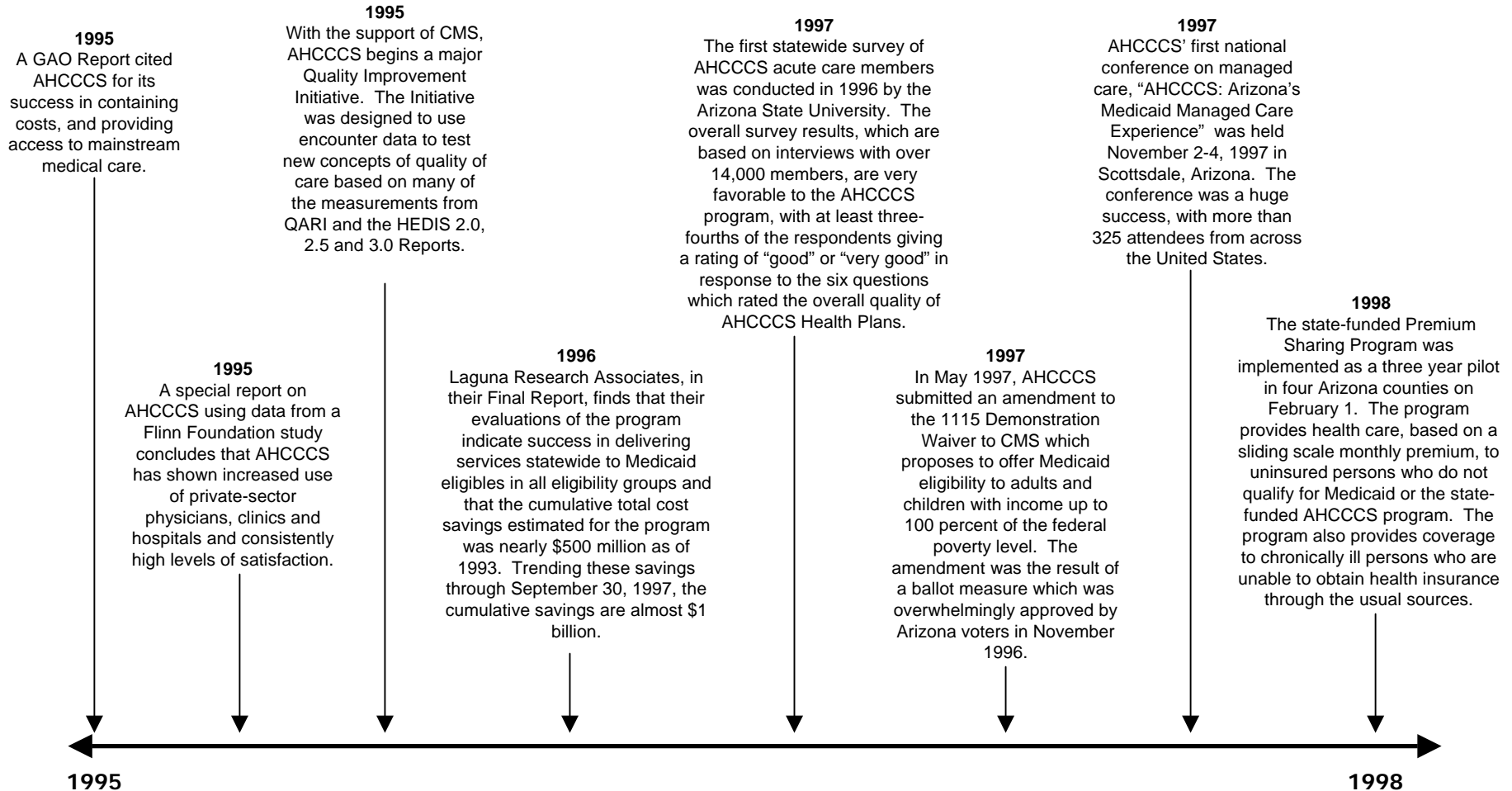
1981

1989

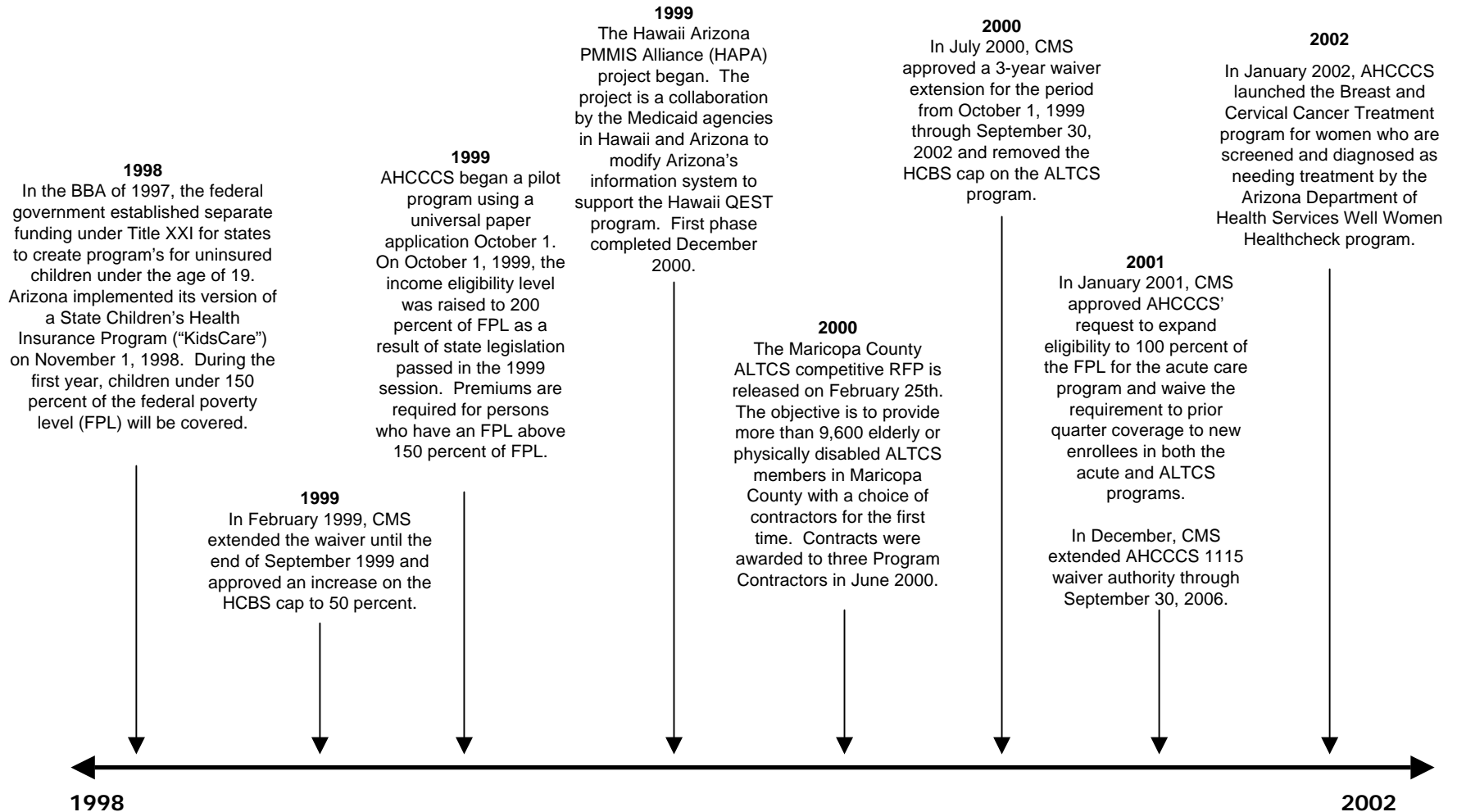
Arizona's AHCCCS Years



Arizona's AHCCCS Years



Arizona's AHCCCS Years



Arizona's AHCCCS Years

2003

On January 1, 2003 eligibility for parents of SCHIP children with household income up to 200% FPL was established.

2003

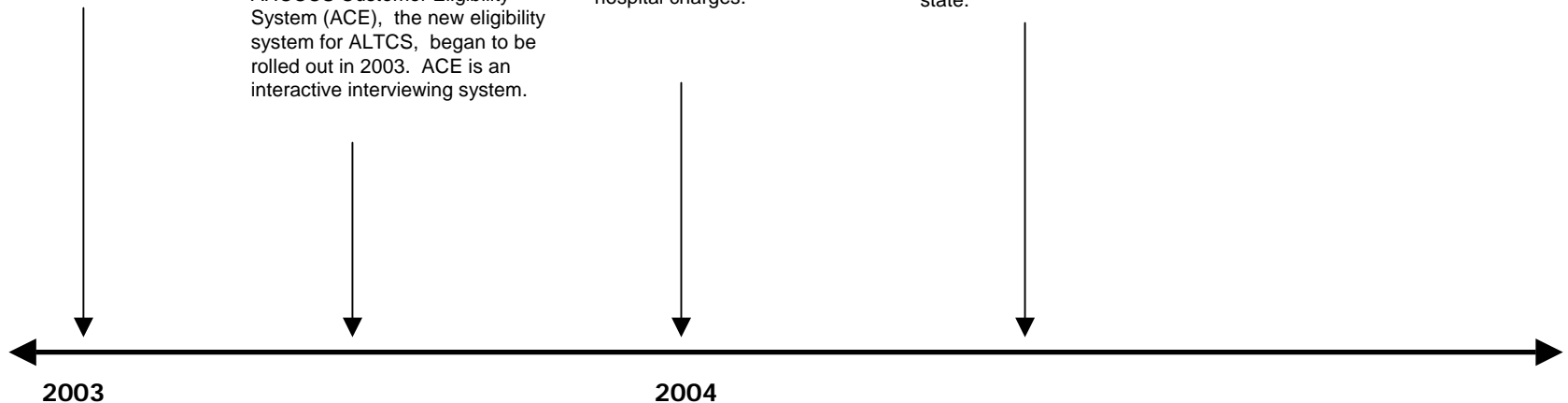
AHCCCS Customer Eligibility System (ACE), the new eligibility system for ALTCS, began to be rolled out in 2003. ACE is an interactive interviewing system.

2004

On July 1, 2004, AHCCCS began reimbursing outpatient hospital services using a hospital-specific cost-to-charge ratio in an effort to control hospital charges.

2004

Maricopa county long-term care program contracts were extended to September 30, 2006, to allow the alignment of all long-term care program contractors bid cycle across the state.



CHAPTER 2

ACUTE CARE PROGRAM

The AHCCCS acute care program is a statewide, managed care system which delivers acute care services through eight prepaid, capitated Health Plans. As of October 1, 2004, AHCCCS' Health Plans were delivering managed care to 753,343 Medicaid members. The Title XXI program, KidsCare, is covered in Chapter 4. The Healthcare Group is covered separately at the end of this Chapter.

Chart 2A depicts the acute care prepaid model. Access to care has been a major goal of AHCCCS since the program began in 1982. In May 2003, AHCCCS awarded acute care contracts to eight contractors for a three-year period beginning October 1, 2003. Acute care contracts were awarded by Geographic Service Area (GSA), typically a two county area. All members have a choice of at least two health plans within a GSA.

AHCCCS members have access to care in the over 85% of private physician offices in Arizona. This mainstreaming of members into the private physician sector was the direct result of a working partnership between AHCCCS and the Health Plans. Mainstreaming

members is a critical element in the success of the acute care program. The AHCCCS network also includes Federally Qualified Health Centers (FQHC) which further expand access to health care in medically underserved areas.

Eligibility for the AHCCCS acute care program is based on federal requirements, Arizona Revised Statutes (<http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp>) and Arizona Administrative Code (http://www.azsos.gov/public_services/Table_of_Contents.htm). Appendix I displays the current AHCCCS eligibility requirements for all major eligibility groups.

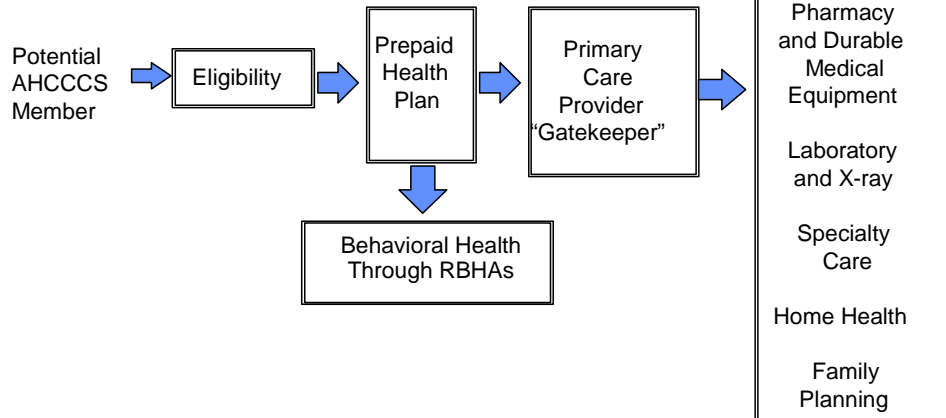
ELIGIBILITY

Medicaid Groups

As of September 30, 2004, AHCCCS covered the following groups of people under the Medicaid Program:

- Families and children under Section 1931 of the Social Security Act
- Individuals or couples without dependent children with income at or below 100 percent FPL
- Individuals or families who incur sufficient medical expenses that, when deducted from their income, reduces their income to under 40 percent of the FPL
- Pregnant women with income at or below 133 percent FPL

Chart 2A
ACUTE CARE PREPAID MODEL



- Children under age one with family income at or below 140 percent FPL
- Children ages 1 thru 5 whose family income is at or below 133 percent FPL
- Children ages 6 thru 18 whose family income is at or below 100 percent FPL
- Children who are eligible for Title IV-E Foster Care or Adoption Subsidy
- Newborns of mothers who were receiving Medicaid when the child was born
- Individuals who are aged, blind or disabled with income at or below 100 percent FPL
- Persons under age 21 who were in foster care on their 18th birthday
- Persons who meet the requirements of one of the categorically-linked Medicaid programs except for citizenship or qualified immigrant status (emergency services only)
- Persons eligible for the Medicare Cost Sharing Programs (QMB, SLMB, QI 1's)
- Women under age 65 diagnosed as needing treatment for breast or cervical cancer
- Parents of children eligible for Title XIX or XXI with income between 100% and 200% FPL
- Working, disabled persons over age 16 and under age 65 with income below 250% FPL (Freedom to Work)

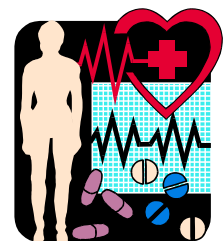
The Arizona Department of Economic Security (DES) processes applications and determines eligibility for most acute categories. AHCCCS determines eligibility for the SSI-related groups, Medicare Cost Sharing groups, women diagnosed with breast or cervical cancer, Freedom to Work and parents of children eligible for Title XIX or XXI. Appendix II displays the enrollment numbers for the various covered groups from 1982 to present.

SERVICES

Appendix III lists the numerous services provided to AHCCCS members.

Behavioral Health Services

When the AHCCCS program began in 1982, the State decided to delay the implementation of behavioral health services until the new Medicaid program could stabilize. In 1990, AHCCCS began phasing-in comprehensive behavioral health services starting with seriously emotionally disturbed (SED) children under the age of 18 who required residential care. Over the next five years other populations were added, such as non-SED children in 1991, adults with serious mental illness (SMI) in 1992 and adults needing general mental health and/or substance abuse services in 1995.



Behavioral health services for all Acute Care Medicaid and KidsCare eligible persons are administered under contract with the Arizona Department of Health Services (ADHS) who subcontracts with the following five Regional Behavioral Health Authorities (RBHAs) and four tribal RBHAs to provide services:

- The Excel Group serves Yuma and LaPaz Counties;
- Pinal/Gila Behavioral Health Authority (PGBHA) serves Pinal and Gila Counties;
- Community Partnership of Southern Arizona (CPSA) serves Pima, Cochise, Graham, Greenlee and Santa Cruz Counties;
- Northern Arizona RBHA (NARBHA) serves Mohave, Coconino, Navajo, Yavapai and Apache Counties;
- Value Options serves Maricopa County;

- Pascua-Yaqui Tribal RBHA provides services to Pascua-Yaqui tribal members;
- The Gila River Tribal RBHA provides services to Gila River tribal members;
- The Navajo Nation Tribal RBHA provides services to Navajo Nation tribal members; and
- The Colorado River Tribal RBHA provides services to Colorado River tribal members.

Behavioral health services for people who were not seriously mentally ill and age 18, 19 or 20, were provided through the AHCCCS Health Plans until October 1, 1999. Legislation was passed in 1999 that enabled these AHCCCS members to receive behavioral health services through the RBHA's, the same as other AHCCCS members. On September 30, 2004, there were 76,795 AHCCCS members enrolled with ADHS.

For more information on AHCCCS' Behavioral Health Services, please refer to the Behavioral Health Services Guide by visiting <http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/index.asp>.

Targeted Case Management

In early 1998, a targeted case management program was implemented for individuals who are developmentally disabled, meet the financial requirements of Title XIX and need case management support, but do not qualify for the long-term care program. Case managers employed by the Department of Economic Security/Division of Developmental Disabilities provide intervention to ensure that the changing needs of the member and family are recognized on an on-going basis and that the widest array of appropriate options are presented for meeting those needs.

SERVICE DELIVERY

AHCCCS was the first statewide, managed care Medicaid program in the nation to rely on Health Plans to deliver acute care services to both Medicaid and state-funded populations. Financing for the program is based on a prepaid, capitation approach with the AHCCCS Health Plans assuming the financial risk for the delivery of services. AHCCCS Health Plans are defined by state statute and are regulated and monitored by AHCCCS based on strict financial and operational standards.

For the contract year beginning October 1, 2003, AHCCCS acute-care contracts were awarded for a three-year period, with two one-year renewal options. In order to secure an AHCCCS contract, prospective contractors responded to a Request for Proposal (RFP) by submitting a bid that included proposed capitation rates for all AHCCCS services. During the contract negotiation process, prospective contractors that responded to the RFP segregated their bids by a specified geographic service area and specified the fixed, per member, per month capitation rate for the various rate codes. Critical elements in the bid evaluation performed by AHCCCS included an assessment of how each prospective contractor would meet all financial and operational requirements, ensure quality in the delivery of services and provide a sufficient provider network to meet provider accessibility requirements. AHCCCS also evaluated each capitation proposal based on capitation rate ranges, which had been actuarially established to determine whether the bid was too high for the actuarial range or too low for the delivery of quality services. Once a Health Plan was awarded a contract, services had to be available and accessible to the enrolled members based on performance standards specified in the contract. AHCCCS monitors each Health Plan for compliance with the contract as discussed more fully in Chapter 5.

Exhibit 2.1 provides information on the Health Plans contracted with AHCCCS as of October 1, 2004. Exhibit 2.2 includes the Health Plans and the total enrollment by county.

AHCCCS allows members to choose a Health Plan from those available in the GSA in which the member resides. After choosing a Health Plan, the member must then choose a primary care provider who is affiliated with that Health Plan. Historically, approximately 60 percent of all Medicaid members select a Health Plan. If

the member does not select a Health Plan, AHCCCS automatically assigns the person to an available Health Plan in the member's GSA.

All members have an extensive choice of primary care providers since over 85 percent of the licensed physicians, and many practitioners, choose to participate in AHCCCS. In the rural areas of the State, the choice is generally more limited due to a general shortage of providers.

The role of the primary care provider is critical to the success of the program since these professionals are the gatekeepers for the system, providing all medical care and arranging referrals for specialty care. There are currently three exceptions to the gatekeeper approach:

- Dental services do not require authorization from the primary care provider,
- The network for the behavioral health system uses RHBAs in the gatekeeper role for behavioral health services, and
- Women can elect an OB/GYN provider as their primary care provider.

Once a member chooses a Health Plan, or is assigned to a Health Plan if no choice is made, the member is "locked-in" to the Health Plan until their enrollment anniversary date. During the annual enrollment, a member is given a 30-day period in which the member can change Health Plans. AHCCCS allows an exception to the lock-in period primarily to provide for medical or family continuity of care. Historically, the number of members electing to change Health Plans has been low, averaging four to five percent during open enrollment. In 1998, AHCCCS transitioned from the traditional annual enrollment to an annual enrollment choice.

Native Americans who are AHCCCS members have the option to select either the Indian Health Service (IHS) or an AHCCCS Health Plan located off-reservation for Medicaid acute services. If the member chooses IHS, all available services are provided by IHS. However, if a Medicaid covered service is not available through IHS or if IHS does not have funding to pay for the service, the member may obtain services on a Fee-for-Service (FFS) basis through AHCCCS. A member who has chosen IHS is not "locked-in" and may change to an AHCCCS Health Plan at any time. On October 1, 2004, there were 84,843 Native Americans using IHS as their provider of acute care medical services.

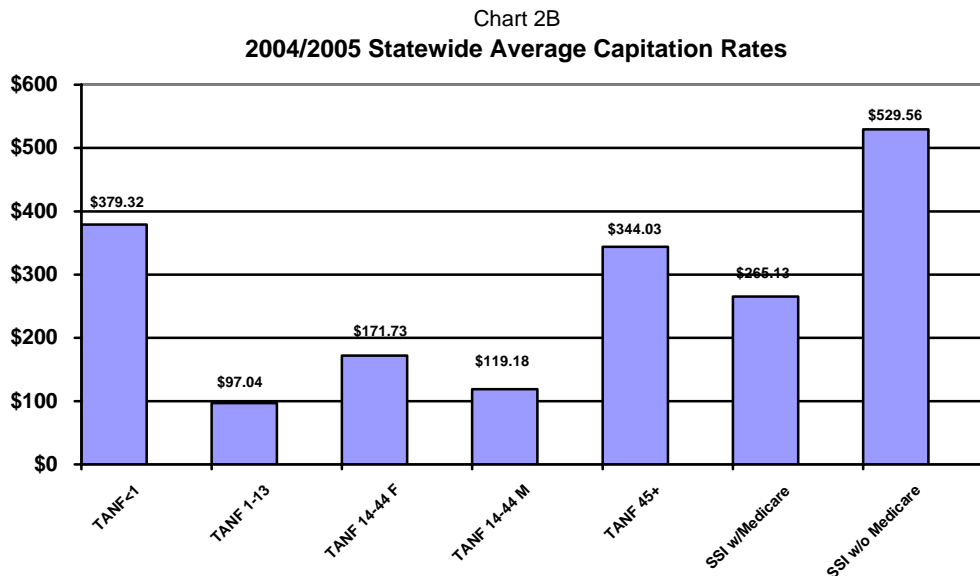


Except for those Native Americans who choose the IHS as their provider or foster children enrolled in the Comprehensive Medical and Dental Plan (CMDP), all members are guaranteed eligibility for an initial five-month continuous period plus the month the member was enrolled. This guaranteed enrollment period is important to the member and the Health Plan for two reasons: the member has the security of continuous health care for at least five months; and, the Health Plan has an opportunity to stabilize medical conditions and reduce their financial risk for sick members through the assurance of at least five months of capitation payments.

HEALTH CARE CAPITATION

Health Plans are prospectively paid a fixed monthly capitation, which is adjusted for various risk factors, such as the age and gender of each member. AHCCCS uses actuaries to develop the rate ranges, not the actual rates, which are the basis for the capitation rates. When a Health Plan submits a bid to participate in the AHCCCS program, the Health Plan agrees to provide a specified set of services to any individual within the geographic area for the capitation rate established by their contract with AHCCCS. Under this arrangement, Health Plans are at-risk for the services provided to a member since they must absorb the loss if the medical costs for a member exceed the monthly capitation payment made to the Health Plan. Reinsurance, which provides some measure of financial protection against significant medical costs to the Health Plans, is discussed in Chapter 5.

The capitation rates for seven acute care rate groups are provided in Chart 2B. The Statewide Average Capitation Rates in Chart 2B do not include FFS, reinsurance or Medicare premiums.



PROGRAM FUNDING

AHCCCS is funded by a combination of federal, state and other funds as reflected in Appendix IV.

For all Medicaid members, CMS pays a federal match to the state based on an annual matching percentage established in federal regulation. For federal fiscal year beginning October 1, 2003, through June 30, 2004, the federal match was 70.21 percent and for July 1, 2004, through September 30, 2004, the federal match was 67.26 percent for each Medicaid dollar spent in the State. The state match was 29.79 percent and 32.74 percent respectively and was paid with a combination of General Fund monies, a fixed contribution from each county and tobacco related dollars. The federal match percentage changes at the beginning of each federal fiscal year.

HEALTHCARE GROUP

In addition to participating in the AHCCCS program, three Health Plans participate in the privately administered Healthcare Group, which was created by the Legislature to provide an affordable health care option for small employers. As of October 1, 2004, this organization served approximately 11,734 employees and their dependents in Arizona (see Chart 2C). A self-employed individual or employer with 50 or fewer employees is eligible to participate in Healthcare Group by purchasing health care for their employees and the employee's dependents through the participating Health Plans. Employers may have a choice of Health Plans depending on the county in which the business is located. Employers will have a choice of benefit levels with varying cost sharing options.

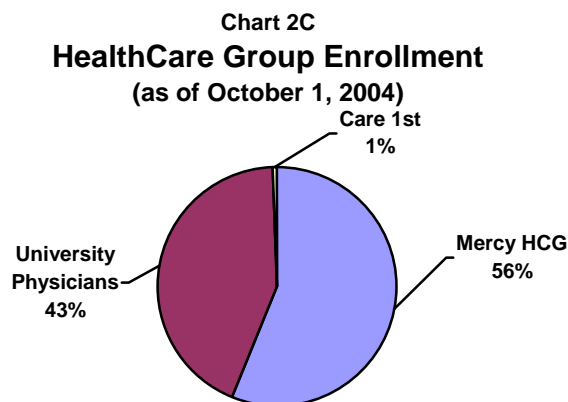


Exhibit 2.1

AHCCCS HEALTH PLANS

(As of October 1, 2004)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	DATE OPERATIONS COMMENCED	COUNTIES OF OPERATION	ENROLLMENT
Arizona Physicians IPA	Americhoice/UnitedHealth Group	Corporation For profit	10/1/82	Apache, Cochise, Coconino, Graham, Greenlee, LaPaz, Mohave, Maricopa, Navajo, Pima, Santa Cruz , Yavapai, Yuma	284,721
Care 1 st Healthplan Arizona	Care 1 st Health Plan	Corporation For profit	10/01/03	Maricopa	30,349
Comprehensive Medical and Dental Program	Department of Economic Security, State of AZ	Government Not for profit	10/1/90	Statewide	8,546
Health Choice Arizona	IASIS Healthcare Corporation	Corporation For profit	10/1/90	Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal	105,372
Maricopa Managed Care	Maricopa County Government	Government Not for profit	10/1/82	Maricopa	39,997
Mercy Care Plan	Catholic Healthcare West Arizona Carondelet Health Care Group (Tucson)	Corporation Not for profit	10/1/83	Cochise, , Graham, Greenlee, La Paz Maricopa, Pima, , Yavapai, Yuma	223,143
Phoenix Health Plan/ Community Connection	Abrazo Healthcare	Corporation For profit	10/1/83	Gila, Maricopa, Pinal	96,700
Pima Health Plan	Pima County Government	Government Not for profit	10/1/82	Pima, Santa Cruz	27,169
University Family Care	University Physicians Inc.	Corporation Not for profit	10/1/97	Pima	14,839

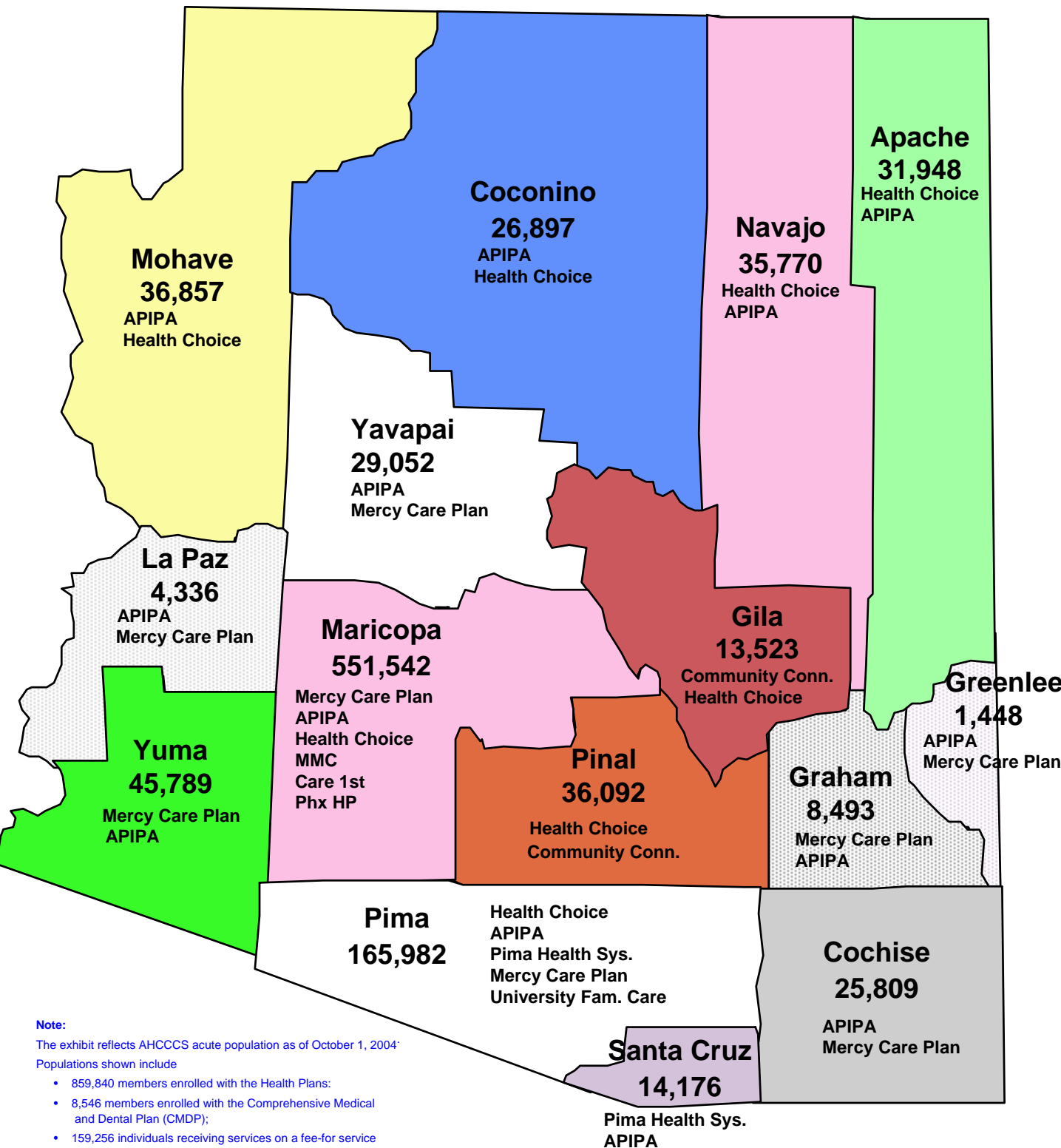
Note:

Exhibit 2.1 provides information on the health plans contracted with AHCCCS as of October 1, 2004.

Exhibit 2.2

AHCCCS AND KIDSCARE MEMBERS BY COUNTY AND AHCCCS HEALTH PLANS BY COUNTY

(October 1, 2004)



CHAPTER 3

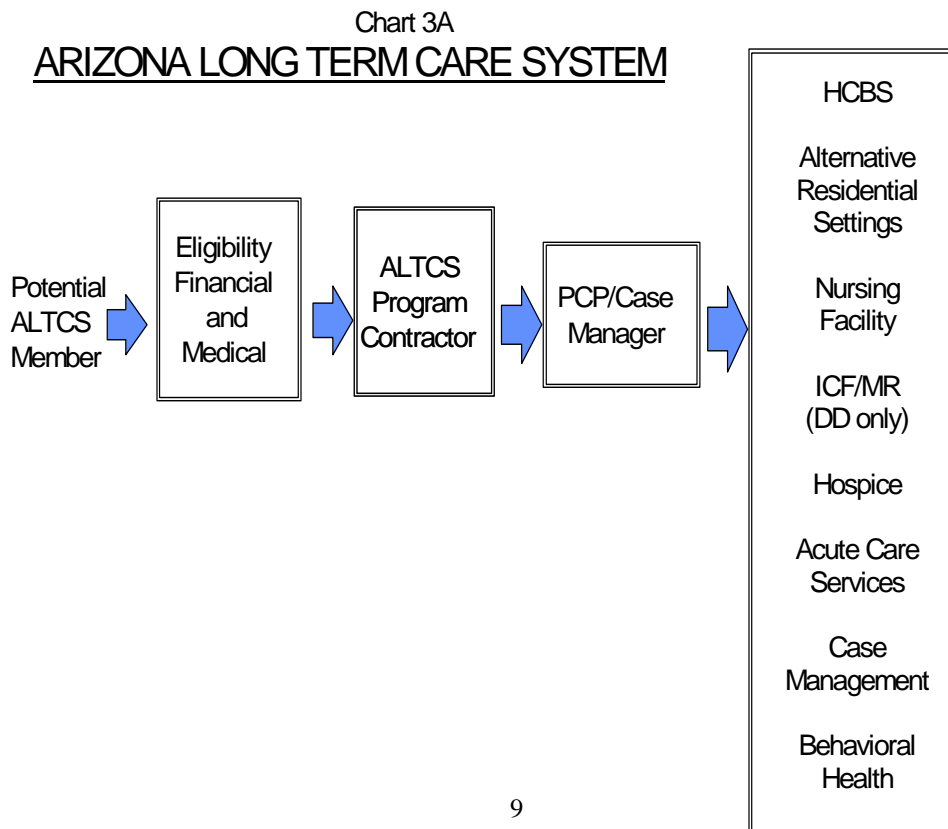
ARIZONA LONG TERM CARE SYSTEM

In 1987, Arizona passed legislation to establish the Arizona Long Term Care System (ALTCS) for the delivery of long term care services. ALTCS was implemented on December 19, 1988, for the developmentally disabled (DD) population. The long term care program for the elderly or physically disabled (EPD) population was implemented on January 1, 1989. As of October 1, 2004, the ALTCS program served 39,987 members; 16,126 were persons who are DD and 23,861 were persons who are EPD.

ALTCS offers a complete array of acute medical care services, institutional services, behavioral health services, home-and-community-based services (HCBS) and case management services for all eligible persons. A listing of the services and the approved settings is provided in Appendix III.

ALTCS is unique in that all covered services are integrated into a single delivery package, coordinated and managed by the Program Contractors listed in Exhibit 3.1. Program Contractors provide services for ALTCS members in the same way that Health Plans provide acute care services to AHCCCS enrolled members. Until October 1, 2000, only one Program Contractor operated in each county and members were enrolled with the Program Contractor in their county of residence. On June 1, 2000, AHCCCS awarded contracts to three Arizona health care companies to provide choice to elderly and physically disabled ALTCS members residing in Maricopa County. This allowed a choice of ALTCS Program Contractors beginning October 1, 2000. This new development was initiated by the Arizona Legislature in 1997 because lawmakers sought a wider choice of providers for Medicaid members.

Once enrolled, the member has a choice of available primary care providers who coordinate care and act as gatekeepers. Chart 3A displays the main components of the ALTCS program. Exhibit 3.2 shows the Program Contractor for each county and the ALTCS member enrollment for each contractor as of September 30, 2004.

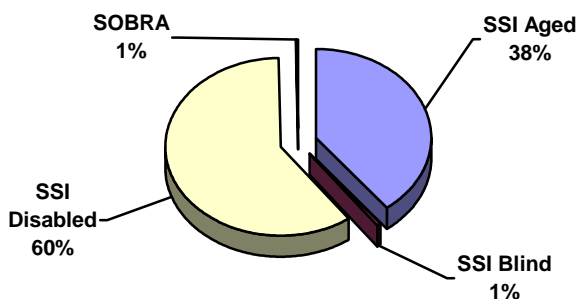


ELIGIBILITY

Financial Eligibility

Individuals must be financially eligible for ALTCS. The Legislature has established ALTCS financial eligibility at 300 percent of the Federal Benefit Rate (FBR), which is used by the Social Security Administration to determine eligibility for Supplemental Security Income (SSI). Effective January 1, 2004, an individual may have up to \$1,692. An eligible individual may have no more than \$2,000 in resources.

Chart 3B
ALTCS Enrollment by Type
(as of October 1, 2004)



Nearly all ALTCS members meet financial eligibility requirements based on the established SSI criteria. A small number of individuals are determined eligible based on SOBRA criteria (see Chart 3B). All ALTCS members residing in a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR) are required to contribute a share of the cost for their institutional care, which is calculated by taking an individual's income and subtracting certain allowable deductions. Appendix I contains specific ALTCS eligibility criteria.

Medical Eligibility

Once financial eligibility has been established, a Pre-Admission Screening (PAS) is conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. If deemed necessary, the registered nurse or social worker may refer the case to a physician for a final determination. AHCCCS has developed five standardized PAS instruments, one is used to screen persons who are elderly and/or physically disabled and the others are age specific for DD.

The PAS instruments use weighted scores to provide information on the functional, medical, nursing and social needs of an individual, which are the basis for determining medical eligibility for ALTCS services. Targeted groups are reassessed on an annual basis and others are reassessed when a change occurs.

On September 1, 1995, AHCCCS implemented a new ALTCS Transitional Program, which allows AHCCCS to complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at "immediate risk of institutionalization" based on the PAS conducted at the time of the redetermination. If determined eligible, AHCCCS transfers the member to the ALTCS Transitional Program which limits institutional services to 90 days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services. On September 30, 2004, there were 4,000 eligible members in the ALTCS Transitional Program; 2,055 members who are DD and 1,945 members who are EPD.

SERVICES

Acute Medical Care

ALTCS members receive the same acute services listed in Appendix III. The Program Contractor assigns a case manager to each ALTCS member. The case manager coordinates care with the primary care provider and is responsible for identifying, planning, obtaining and monitoring appropriate services that meet the member's needs.

Home and Community-Based Services (HCBS)

ALTCS provides a comprehensive HCBS package in settings that may include a member's home, as identified in Appendix III.

Prior to October 1, 1999, there was a federal restriction on the number of HCBS slots available to the EPD population enrolled in ALTCS. AHCCCS believed that there should be no cap on the HCBS program and each year negotiated with CMS to increase the cap from an initial five percent cap, which was based on the total ALTCS budget (1989), to a 50 percent statewide cap which is based on the total elderly and physically disabled population (1998). CMS notified AHCCCS of the elimination of the HCBS cap effective October 1, 1999. As of September 30, 2004, approximately 60 percent of the EPD population were served within the community. CMS never imposed a similar cap for the DD population and almost all of this population is served within the community rather than through more restrictive and costly institutional settings.



Alternative Residential Settings under HCBS

ALTCS approved HCBS settings for EPD members include the member's home, adult foster care, assisted living home, assisted living centers, level II and level III behavioral health facilities, hospice, group homes for traumatic brain injured members and rural substance abuse transitional agencies. Since August 2001, members who are elderly and/or physically disabled (EPD) may also use DD alternative residential settings as appropriate.

The ALTCS program has expanded alternative residential settings to meet the needs of the members.

**The ALTCS
program
has
expanded
alternative
residential
settings.**

Initially, an ALTCS member could only receive HCBS in their own home or an adult foster care home. In 1993, the Arizona Legislature established a Supportive Residential Living (SRL) three-year pilot in Maricopa County to expand the ALTCS members' options to remain in the community. In 1996, alternative residential settings were expanded to Adult Care Homes, also as a pilot program. In 1996, the Arizona Legislature established SRL's as permanent, statewide settings available to ALTCS members. In 1998, the Arizona Legislature consolidated the licensure of adult care homes (ACH), adult foster care homes, supportive residential living centers (SRL), supervisory care homes and unclassified residential care institutions under the single licensure classification of assisted living facilities. On October 31, 1998, when the new assisted living facility license was implemented, ACH's ceased being a pilot program and became a permanent alternative setting available to ALTCS members.

Effective October 1, 1999, AHCCCS implemented a three-year Alzheimer's Treatment Assistive Living Facility pilot project in a limited number of facilities. The purpose of the pilot was to determine if a new type of Alzheimer's housing facility could provide cost effective quality care in a facility which is less restrictive than a nursing facility.

By providing a variety of alternative settings with differing levels of care, ALTCS members are able to delay institutionalization or, in some cases, transfer from nursing home care into an HCBS setting. More important than the savings experienced by using HCBS, this alternative to institutionalization provides members with a degree of independence and control not available in an institutional setting.

Institutional Care

ALTCS provides institutional care in either a Medicare/Medicaid approved nursing facility, hospice, an ICF/MR, an inpatient psychiatric hospital, a level I behavioral health residential treatment center or a Level I behavioral health sub-acute facility if the member requires the level of care in these facilities.

Chart 3C Program Contractor Placement Comparison to Statewide Percentages as of 8/01/04

Setting	Statewide %	CHS	ES	MLTC	MC LTC	PHS	P/G LTC	YLTC
Nursing Facility	38.24%	41.39%	41.03%	42.57%	28.10%	39.19%	36.01%	41.71%
HCBS Community	15.29%	3.96%	18.59%	17.00%	13.46%	16.99%	8.94%	10.92%
HCBS Home	44.42%	53.48%	38.72%	38.16%	55.52%	42.05%	53.88%	46.23%
Acute Services Only	1.21%	0.75%	0.91%	1.53%	1.37%	1.24%	0.45%	0.66%
Not placed	0.85%	0.43%	0.75%	0.74%	1.56	0.53%	0.72%	0.47%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NOTE: Report is based on the number of members enrolled with a Program Contractor on the last day of the reporting period. Enrollment does not include Ventilator Dependent members.

SERVICE DELIVERY

Elderly and Physically Disabled

A network of seven Program Contractors located throughout the State deliver ALTCS services for the elderly or physically disabled population. On October 1, 1996, AHCCCS awarded contracts for up to a five-year period, subject to annual renewal by AHCCCS. At that time, the two largest Arizona counties, Maricopa and Pima, were required by law to be Program Contractors and three other counties (Yavapai, Cochise and Pinal) had the right of first refusal to be a Program Contractor for their respective counties. With the bid process for the contract beginning October 1, 2000, the ALTCS program began the process of competitively bidding the services of the Program Contractors. Since October 2000, Maricopa County has three contractors from which members may choose. As of October 2001, all State GSA's are part of the competitive bid process.

Developmentally Disabled (DD)

By statute, ALTCS services for the DD population are delivered by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) under a capitation arrangement with AHCCCS. DES/DDD operates in the same manner as other Program Contractors and additionally administers a 100 percent state-funded program for persons who are DD and not eligible for ALTCS. Once enrolled with

DES/DDD, a DD member chooses a primary care provider who coordinates the member's care in coordination with the member's case manager.

Tribal Elderly and Physically Disabled

As of September 30, 2004, seven tribes have signed Intergovernmental Agreements with AHCCCS to deliver case management services to coordinate HCBS to Native Americans who reside on-reservation and services for Native Americans with an on-reservation status and reside in a nursing facility. The seven tribes are Gila River Indian Community, Hopi Tribe, Navajo Nation, Pascua Yaqui Tribe, San Carlos Apache Tribe, White Mountain Apache Tribe, and Tohono O'Odham Nation. In April 1997, AHCCCS signed an agreement with Native American Community Health Center (NACHC) to provide case management services to "on reservation" Native American ALTCS members who do not receive ALTCS case management from a tribe. On September 30, 2004, there were 1,652 Native Americans receiving case management through a tribal agreement or through NACHC.

CAPITATION

Parallel to the acute care program, AHCCCS pays Program Contractors prospectively on a capitated, per member, per month basis. ALTCS capitation rates are blended rates, which include nursing facility costs, HCBS, acute medical care services, behavioral health services, case management services and administrative costs. Beginning October 1, 2004, the weighted average statewide capitation rate paid to Program Contractors for covered services provided to the elderly or physically disabled population is \$2,766 per member per month. The weighted average for the DD population beginning July 1, 2004, is \$2,923 per member per month. The rates are based on AHCCCS FFS rates, Program Contractor financial statements, service utilization data and historical trends. In a contract year this information is used to determine the capitation rate ranges, in renewal years this information is used to adjust rates.

PROGRAM FUNDING

ALTCS is funded by federal, state and county monies as reflected in Appendix IV. Historically, the county contribution was established by the Legislature and the counties paid most of the State share for the ALTCS program. In November 1997, the State Legislature froze the county's contributions at SFY 1997/1998 levels and required the State and counties to each pay 50 percent of any increase effective through SFY 2000/2001. In December 2001, the State legislature created a revised funding model effective with SFY 2001/2002 and forward where increases are funded at a legislatively determined percent. State match for the DD population is provided to AHCCCS by DES/DDD and then deposited into an intergovernmental fund with AHCCCS having sole disbursement authority.

Exhibit 3.1

ALTCS PROGRAM CONTRACTORS

(As of October 1, 2004)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	DATE OPERATIONS COMMENCED	COUNTIES OF OPERATION	ENROLLMENT	SERVICE MODEL
Cochise Health Systems	Cochise County Government	Government Not for profit	11/1/93	Cochise, Graham, Greenlee	940	IPA
Department of Economic Security/Division of Developmental Disabilities	State of Arizona	Government Not for profit	12/19/88	All Counties	16,126	Contracts with AHCCCS Health Plans for acute care services
Evercare Select	Managed Care Solutions, Inc.	Corporation For profit	1/1/89	Apache, Coconino, Maricopa, Mohave, Navajo, Yavapai, Yuma	3,865	IPA
Maricopa Long Term Care Plan	Maricopa County Government	Government Not for profit	1/1/89	Maricopa	6,652	Mixed
Mercy Care Plan	Mercy Healthcare Arizona	Corporation Not for profit	10/1/00	Maricopa	4,742	IPA
Pima Long Term Care	Pima County Government	Government Not for profit	1/1/89	Pima, Santa Cruz	3,924	Mixed
Pinal/Gila County Long Term Care	Pinal County Government	Government Not for profit	10/1/90	Pinal, Gila	1,122	IPA
Yavapai County Long Term Care	Yavapai County Government	Government Not for profit	10/1/93	Yavapai	1,054	IPA

Note:

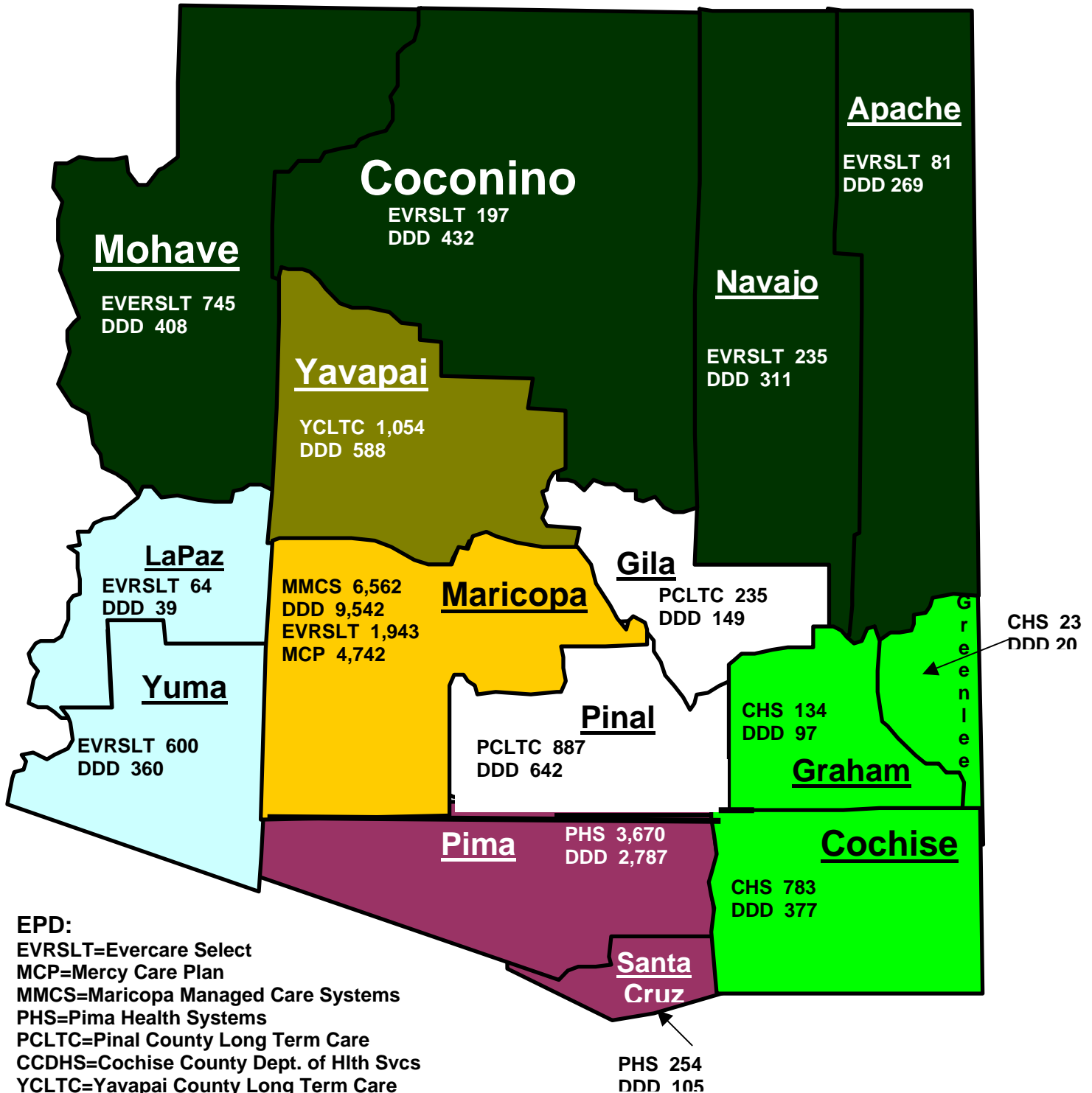
On October 1, 2004, there were 1,652 Native American members being case managed through Arizona tribes or Native American Community Health, a tribal organization.

This exhibit shows the program contractor for each county and the ALTCS member enrollment for each contractor as of October 1, 2004.

Exhibit 3.2

ALTCS ENROLLMENT BY COUNTY

As of October 1, 2004



*American Indian Contractors=**1,561** (included in total)

DDD-**16,126** EPD=**22,209** & **NACH=**91**

**Native American Community Health Care

Source: ALTCS Enrollment Summary Report **TOTAL 39,987****

Chapter 4

KIDSCARE – ARIZONA’S SCHIP PROGRAM

In May 1998, the Arizona Legislature authorized the implementation of a stand-alone Title XXI Child Health Insurance Program. This program is referred to as Arizona's KidsCare Program and was implemented on November 1, 1998.

Arizona’s income threshold is set at 200 percent FPL with no resource test on this population. A screening and referral process is used to determine whether a child is eligible for Medicaid (Title XIX) prior to a determination of eligibility for KidsCare.

Health care services are provided through established AHCCCS health plans. All eligible children have a choice of available contractors and primary care providers in their GSA. Additionally, Native Americans can elect to receive services through a health plan or Indian Health Services (IHS).

KIDSCARE: POPULATION

As of September 30, 2004, KidsCare has enrolled a total of 214,099 children to be insured. Of this number, 165,928 (78 percent) have been found eligible for Medicaid rather than KidsCare. Chart 4A illustrates the total number of children approved for health insurance because of KidsCare applications.

Chart 4A
Total Kids Enrolled for Health Coverage due to KidsCare Applications

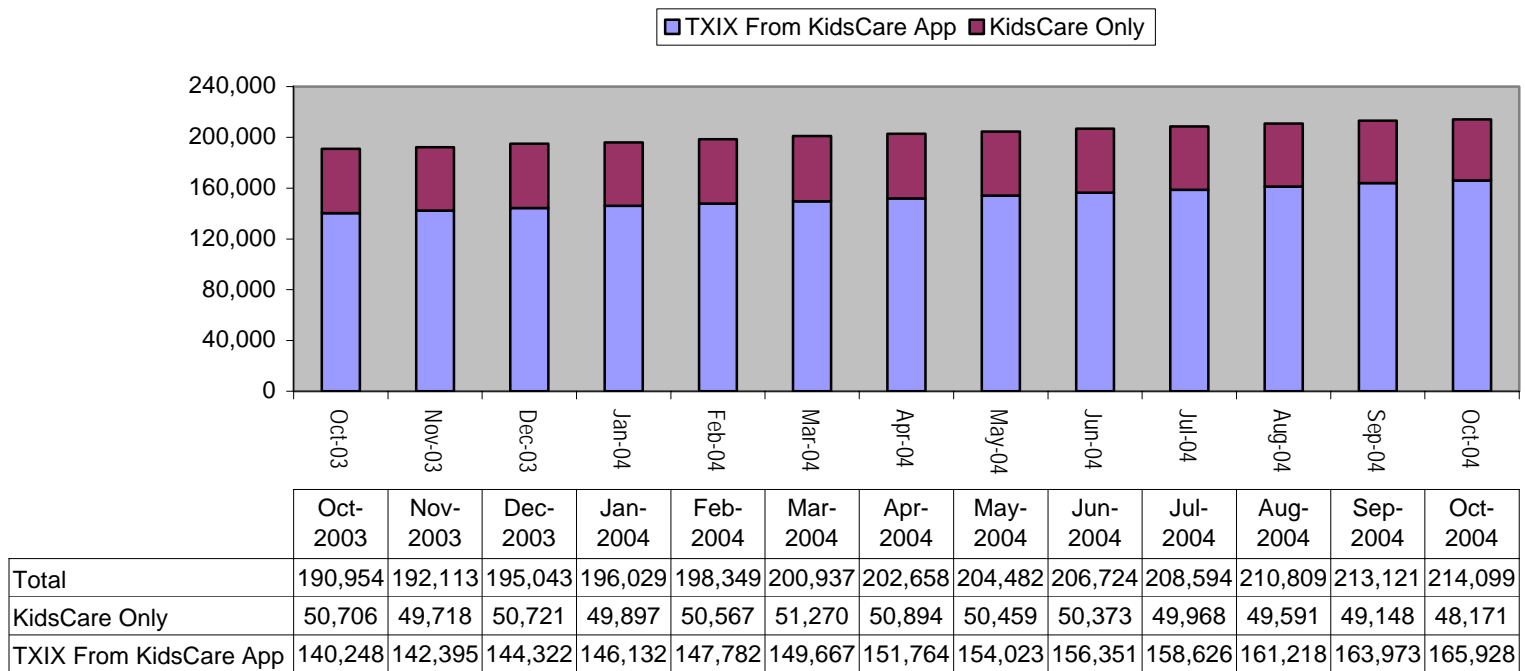
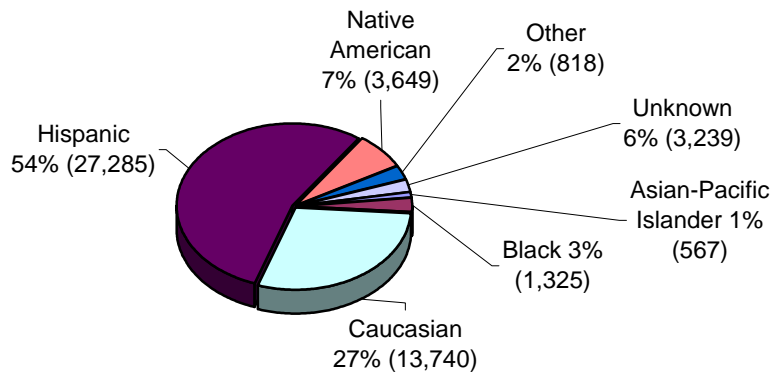


Chart 4B shows the ethnicity of KidsCare children as reported by the applicants.

Chart 4B
KidsCare Children Population by Ethnicity



KIDSCARE: BUDGET

➤ **State and Fiscal Expenditures**

Chart 4C shows KidsCare program expenditures over a four-year period, including actual expenditures for State fiscal years 2001-2004 and projected expenditures for State fiscal year 2005.

Chart 4C
EXPENDITURES

State Fiscal Year 2002	State Fiscal Year 2003	State Fiscal Year 2004	State Fiscal Year 2005 (Projected)
\$58,275,572	\$ 58,247,770	\$67,849,815	\$74,105,900

Based on current enrollment numbers, federal funding percentages are sufficient to fund the program for the upcoming year.

➤ **Premiums Implemented**

On October 1, 1999, KidsCare implemented premiums for families with an income above 150 percent of the Federal Poverty Level (FPL). On July 1, 2004, premiums were implemented for families with income between 100 percent and 150 percent of the FPL. The 2004 premium amounts are represented in Chart 4D:

Chart 4D
PREMIUM AMOUNTS

Federal Poverty Levels (FPL)	1 st Child	More than 1 Child
Above 100% - 150%	\$10.00	\$15.00 Total
Above 150% - 175%	\$20.00	\$30.00 Total
Above 175% - 200%	\$25.00	\$35.00 Total

As of September 30, 2004, there were 25,164 households with 40,349 enrolled children required to pay a premium. These children represent 83.8 percent of the children enrolled in KidsCare. From October 1, 2003 through September 30, 2004, premium collection payments totaled \$4,034,374, of which 77.08 percent was returned to CMS.

CHAPTER 5

ADMINISTRATIVE FEATURES AND REGULATORY CONTROLS IN A MANAGED CARE SYSTEM

This Chapter provides an overview of the administrative features and regulatory controls which AHCCCS has implemented in the Medicaid and KidsCare programs. These functions are critical to the success of AHCCCS and allow the program to operate a fiscally responsible managed care program grounded in quality of care.

ADMINISTRATIVE FEATURES

Encounter Data Reporting

As a condition of the 1115 Waiver, CMS requires AHCCCS to submit specific information regarding services provided to Medicaid and KidsCare members. Known as encounter data, these records are submitted to AHCCCS for institutional, professional, dental and prescription drugs. AHCCCS requires all contractors (Health Plans for acute and Program Contractors for ALTCS) to submit encounter data through electronic media within 240 days after the end of the month in which the service was provided.

The purpose of encounter reporting is to:

- Evaluate health care quality and cost effectiveness
- Evaluate individual contractor performance
- Develop and evaluate capitation rates paid to the contractor
- Determine Disproportionate Share payments to hospitals
- Develop FFS payment rates
- Pay reinsurance to the contractor

AHCCCS performs annual validation studies on acute care, long-term care and behavioral health encounter data to ensure that the data reported is timely, accurate and complete. Since sanctions may be imposed on the contractors based on the results of the data validation studies, AHCCCS provides assistance and training to the contractors.

Reinsurance

AHCCCS provides various types of reinsurance coverage to contractors. The purpose of reinsurance is to reduce the financial risk for significant medical expenses incurred by members.

AHCCCS Inpatient Reinsurance

AHCCCS inpatient reinsurance is available to reimburse AHCCCS Health Plans and Program Contractors for a portion of the costs of covered inpatient services. The deductible level for all rate codes and counties is based on the Health Plan's statewide AHCCCS acute care enrollment (excluding SOBRA Family Planning Extension services) as of October 1st of each contract year. The coinsurance percentage is the rate that AHCCCS reimburses the Health Plan for inpatient, covered services incurred above the deductible. The deductible is the responsibility of the Health Plan. Chart 5A details AHCCCS Inpatient Reinsurance.

Chart 5A
AHCCCS Inpatient Reinsurance

<i>Statewide Plan Enrollment</i>	<i>Prospective Reinsurance</i>		
	<i>Title XIX Waiver Group Deductible</i>	<i>Non TXIX Waiver Deductible</i>	<i>Coinsurance</i>
0-34,999	\$15,000	\$20,000	75%
35,000-49,999	\$15,000	\$35,000	75%
50,000 and over	\$15,000	\$50,000	75%

Catastrophic Reinsurance

The reinsurance program also includes a special Catastrophic Reinsurance program. This program is for members diagnosed with hemophilia, von Willebrand's Disease and Gaucher's Disease. There are no deductibles for catastrophic reinsurance cases. All medically necessary services provided during the contract year are eligible for reimbursement at 85% of the Health Plan paid unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, the Administration shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported health plan paid amount, whichever is lower, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts. All catastrophic claims are subject to medical review by AHCCCS.

Transplants

This program covers members who are eligible to receive major organ and tissue transplantation including bone marrow, heart, heart/lung, lung, liver, kidney and other organ transplantation. Bone grafts and cornea transplantation services are not eligible for transplant reinsurance coverage, but are eligible under regular inpatient reinsurance. Reinsurance for transplants is limited to 85% of the AHCCCS contracted amount for the transplantation services rendered or 85% of the Health Plan paid amount, whichever is lower.

ALTCS Reinsurance

ALTCS regular reinsurance covers all medically necessary acute care services, outpatient hospital services and inpatient hospitalizations. The program has an initial deductible level and a subsequent coinsurance percentage. The coinsurance is the rate AHCCCS reimburses the Program Contractor for inpatient services incurred above the deductible. Prospective reinsurance coverage applies to claims incurred in a prospective enrollment period. The deductible level is based on the Program Contractor's statewide ALTCS enrollment as of October 1 of each contract year, as shown in Chart 5B.

Chart 5B
ALTCS Reinsurance

<i>Statewide Plan Enrollment</i>	<i>Prospective Reinsurance</i>			<i>PPC Reinsurance</i>	
	<i>With Medicare Part A</i>	<i>Without Medicare Part A</i>	<i>Coinsurance</i>	<i>All Members</i>	<i>Coinsurance</i>
0-1,999	\$10,000	\$20,000	75%	\$5,000	100%
2,000 +	\$20,000	\$30,000	75%	\$5,000	100%

High Cost Behavioral Health Reinsurance

Members considered by AHCCCS to be high-cost Behavioral Health (BEH) or Traumatic Brain Injured are also covered under regular reinsurance using separate guidelines. Placement into an institutional or HCBS setting for these members must be approved in advance by AHCCCS for the Program Contractor to qualify for reinsurance reimbursement. Behavioral Health/Traumatic Brain Injury reinsurance covers the institutional or HCBS setting only. Except for regular and catastrophic reinsurance, acute care services and all other ALTCS services are not covered by reinsurance for this population. The Program Contractor will be reimbursed at 75 percent of allowable payments with no deductible unless the costs are paid under a subcapitated agreement. In subcapitated agreements, the Administration shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported Health Plan paid amount, whichever is lower, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts.

Prepaid Medical Management Information System (PMMIS)

AHCCCS uses a statewide, automated managed care data system to satisfy the processing and reporting needs of prepaid, capitated programs or any FFS claims. The system, known as PMMIS, is composed of eleven core subsystems, five reporting and quality oversight subsystems and a security subsystem. These subsystems are able to perform the following:

- Generate payments to Program Contractors, Health Plans and providers
- Process enrollment and generate enrollment and capitation files to health plans and program contractors
- Maintain member data history and preserve data on encounters and claims
- Case management and automated referrals
- System information management
- Utilization review and quality management
- Financial management and reporting
- Reinsurance and quality control analyses

Acute Care - PMMIS

PMMIS provides extensive information, retrieval and reporting capabilities to satisfy the data needs of AHCCCS, CMS, other state and federal agencies, Health Plans, providers and members. The system processes both FFS claims and Health Plan encounters for all AHCCCS members, as well as supports the monitoring of service utilization, quality of care, and program expenditures.

ALTCS - PMMIS

PMMIS provides and receives information about ALTCS members after it has been updated from the long-term care eligibility system (ACE).

ACE captures and maintains financial eligibility information, enrollment and termination information.

ACE captures and maintains the detailed results of pre-admission screening and member demographics. Case managers input data into CATS regarding the cost effectiveness of placement options for HCBS, member placement data, service plans and updates.

ACE has been rolled out to all fifteen ALTCS eligibility offices, as well as the SSI-MAO Office. The ACE system is the first major AHCCCS system to be developed off of the mainframe. It resides on an Oracle database, is developed in Visual Basic and runs off of terminal servers.

ACE is part of a larger business re-engineering project for ALTCS and SSI-MAO. Much of its design is based on customer surveys and development by the field office teams. ACE is an interactive interviewing system. By the end of an interview with an eligibility specialist, ACE produces the application for the applicants' signature, as well as other verification forms required in order to determine eligibility. ACE is designed based on Microsoft standards. It has no codes to enter, no screen numbers to memorize and utilizes many drop down lists to supply appropriate answers.

Development is underway for the conversion of KidsCare eligibility from the KidsCare Eligibility Determination System (KEDS) to the ACE system. That conversion is expected to occur sometime in 2005.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) changed certain aspects of the way health care is administered. President Clinton signed the Kassebaum-Kennedy Health Insurance Portability and Accountability Act on August 21, 1996.

HIPAA is designed to expand health coverage by improving the portability and continuity of health insurance coverage in group and individual markets to:

- Combat waste in health care delivery,
- Promote the use of medical savings accounts,
- Improve access to long-term care services and coverage, and
- Simplify the administration of health insurance.

Within this context, HIPAA includes a provision called Administrative Simplification, which is intended to improve the efficiency and effectiveness of the health care system by encouraging the development of standards for the electronic transmission, privacy and security of certain health information. Administrative Simplification is one of the Act's five titles and is a focus for governments across the nation.

Implementing HIPAA standardized the format of our interface files with providers, Health Plans and Program Contractors. In addition, HIPAA defines the standard security requirements and enable us to properly safeguard the data entrusted to us as required by our federal business partners. The project was divided into two parts: Transactions and Code Sets, and Privacy and Security.

For Transactions and Code Sets (TCS), the requirements were implemented for both Arizona and Hawaii in October of 2003.

For Privacy and Security, all requirements have been implemented.

Hawaii/Arizona Partnership

Hawaii and Arizona have entered into an agreement to implement the PMMIS for the State of Hawaii Medicaid program through a joint effort of Hawaii Department of Human Services and AHCCCS in 1999. Both states share the ongoing maintenance and operation of the system.

Copayments

Copayments may be requested from Medicaid members except when the member is under the age of 19, pregnant, enrolled as fee for service or Native American and enrolled with a Health Plan. Copayments are primarily used to control the inappropriate utilization of certain services by members. However, members cannot be denied services due to their inability to pay the copayment. In addition, copayments are not assessed for: family planning services; services to members residing in nursing facilities or Intermediate Care Facilities for the Mentally Retarded (ICF-MR); visits scheduled by a primary care provider which are not requested by the member or drugs/medications.

The Title XIX waiver population has mandatory copayments and services can be denied if the copayment is not paid. The provider may waive the copayment. This includes members who are not Medicaid eligible under a traditional Medicaid group. The Title XIX waiver member is exempt from the copayment if the member is under the age of 19, pregnant, enrolled as fee for service or Native American enrolled with a Health Plan.

REGULATORY CONTROLS

In order to ensure the health of AHCCCS members and avoid problems encountered in earlier years of the program, AHCCCS has established regulatory controls designed to promote the delivery of the highest possible healthcare to members. AHCCCS reports the results of this initiative on a regular basis to the CMS in compliance with the Special Terms and Conditions of the 1115 Research and Demonstration Waiver.

Based on mutual agreement between AHCCCS and CMS, the agency has undertaken a quality improvement initiative consisting of a variety of health care and financial indicators. The agency also submits to CMS utilization reports utilizing data from encounters and claims. In addition, the agency implements a grievance and request for hearing process, a program for combating fraud and abuse program and conducts regular financial and operational reviews of all Health Plans and Program Contractors. Following is a description of the activities undertaken during the reporting period.

Quality Assessment and Performance Improvement

AHCCCS ensures that each contracted health plan (contractor) has an ongoing quality assessment and performance improvement program for the services it furnishes to its members, consistent with regulations under the Balanced Budget Act (BBA) of 1997. Contractors submit encounter data to AHCCCS, which measures each contractor's performance and evaluates its compliance in meeting contractual performance standards for specific health care services.

Acute-care Performance Measures

In CYE 2004, AHCCCS measured performance of seven publicly and privately operated health plans in six measures of preventive health care. In addition, performance of the Comprehensive Medical and Dental Program (CMDP), a health plan operated by the Arizona Department of Economic Security (DES) for children and adolescents in foster care, was measured in one area.

The results reported here should be viewed as *indicators* of utilization of services, rather than absolute rates for how successfully AHCCCS and/or its contractors provide care. Many factors affect whether AHCCCS members use services. By analyzing trends over time, AHCCCS and its contractors can identify areas for improvement and implement interventions to increase access to, and use of, services.

Methodology

AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®) as a guide in determining the methodology for these measures. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. One of the criteria for selecting members to be included in the analyses is that they be continuously enrolled for a minimum period of time with one contractor. Thus, members included in the results of each measure represent only a portion of AHCCCS members, rather than the entire acute-care population.

The current measures utilize data for the contract year ending September 30, 2003 (some measures count health services provided in a previous contract year). Results are reported in aggregate by Maricopa, Pima and the combined rural counties and by individual contractor.

Rotation of Measures

AHCCCS rotates reporting of most measures on a biennial basis, allowing contractors an “intervention year” between measures, thus providing adequate time to focus activities on improving specific rates. Three measures are reported annually. These include Children’s Access to Primary Care Practitioners (PCPs) – Medicaid Members, Children’s Access to PCPs – KidsCare Members and Adults’ Access to Preventive/Ambulatory Health Services.

Highlights of the Data

Results of the six AHCCCS acute-care measures reported here were mixed in the most recent period. Three measures showed no statistically significant change:

- Children’s Access to PCPs – KidsCare Members,
- Adults’ Access to Preventive/Ambulatory Health Services, and
- Breast Cancer Screening.

One measure, Cervical Cancer Screening, improved and one measure, Children’s Access to PCPs – Medicaid Members, declined slightly. Another measure, Timeliness of Prenatal Care, is based on new methodology and is being reported by AHCCCS for the first time.

The following table summarizes overall results of each measure:

Measure	AHCCCS Overall Rate (%)	Previous AHCCCS Overall Rate (%)
Children’s Access to PCPs (Medicaid)	75.7	76.6
Children’s Access to PCPs (KidsCare)	77.7	78.4
Adults’ Access to Preventive/Ambulatory Health Services)	76.2	76.4
Breast Cancer Screening	54.6	55.2
Cervical Cancer Screening	53.2	50.5
Timeliness of Prenatal Care	73.7	Not measured

Individual contractor performance varied widely. One contractor, Mercy Care Plan, met or exceeded the AHCCCS Minimum Performance Standard in five of six measures. Three contractors – Health Choice Arizona, Pima Health System and University Family Care – met or exceeded the minimum standard in four measures. Three other contractors – Arizona Physicians IPA, Maricopa Health Plan and Phoenix Health Plan/Community Connection – met or exceeded the minimum standard in only two measures. CMDP exceeded the minimum standard for its measure, Children’s Access to PCPs – Medicaid Members.

It should be noted that data collection issues related to one contractor might have affected its rates for some measures. Problems with Maricopa Health Plan's claims information system have resulted in a major lag in submitting encounter data to AHCCCS during CYE 2003 and the likelihood that the plan's rates are artificially low. However, it does not appear that Maricopa Health Plan's rates had a substantial effect on AHCCCS overall rates because the health plan represents a relatively small percentage of the acute-care population. Maricopa Health Plan has taken actions to correct its encounter-submission problems.

Performance Improvement

AHCCCS requires corrective action plans from contractors who do not meet the Minimum Performance Standard for any measure or who showed statistically significant declines in their rates, even if they met the minimum standard.

AHCCCS will continue to provide technical assistance, such as identifying new interventions or enhancements to existing efforts to help contractors improve their performance. Contractors may also use this data in developing future Performance Improvement Projects.

ALTCS Performance Measures

Diabetes Care

AHCCCS uses HEDIS specifications as a guideline for measurement of diabetes care services provided to elderly and physically disabled (EPD) members. Three indicators, Hb A_{1c} testing, lipid screening and retinal exams were measured.

Methodology

This study measured services provided from October 1, 2002, through September 30, 2003. It included ALTCS members diagnosed with type 1 or type 2 diabetes, 18 through 75 years of age, and were continuously enrolled with one ALTCS contractor for the entire measurement period (one gap in enrollment, not exceeding 31 days, was allowed). The rates were derived from combined AHCCCS and CMS data, which includes services provided through ALTCS contractors and through the Medicare fee-for-service program.

Highlights of the Data

Hb A_{1c} testing – AHCCCS measured the percentage of members who had one or more glycosylated hemoglobin, or Hb A_{1c}, tests during the measurement period. The overall rate of ALTCS members with diabetes who received an Hb A_{1c} test was 44.6 percent, compared with 47.3 percent in the previous period. Five of seven contractors exceeded the AHCCCS Minimum Performance Standard for this measure and two exceeded the AHCCCS Goal.

Lipid (LDL) screening – AHCCCS measured the percentage of members who had one or more fasting lipid profiles performed during the measurement period or the preceding year. The overall rate of ALTCS members with diabetes who had a lipid screening during the measurement period or the preceding year was 51.3 percent, compared with 43.4 percent for the previous period. Six contractors exceeded both the AHCCCS Minimum Performance Standard and the AHCCCS Goal for this measure.

Retinal exams – AHCCCS measured the percent of members who had a retinal exam by an optometrist or ophthalmologist during the measurement period or the preceding year. The overall rate of members with retinal exams was 30.0 percent. AHCCCS did not previously measure a rate for this indicator because data was not available from CMS when contractor performance was reported in 2003.

It should be noted that AHCCCS' ability to obtain complete data on ALTCS members is limited, especially for those members who are dually enrolled in Medicaid and Medicare, since Medicare is the

primary payer for many services obtained by dually enrolled members. Other AHCCCS studies, based on medical chart review and laboratory records, show that as many as 70 percent of ALTCS members had at least one Hb A_{1c} test during the contract year ending September 30, 2003.

Performance Improvement

AHCCCS requires corrective action plans from contractors who do not meet the Minimum Performance Standard for any measure or that showed statistically significant declines in their rates, even if they met the minimum standard.

In order to assist ALTCS contractors with performance improvement efforts, AHCCCS has compiled information on barriers to effective diabetes management and successful strategies for increasing the use of preventive-care practices. AHCCCS provided individual results to Contractors and is continuing to work with them to improve performance in these indicators.

Home and Community Base Services (HCBS)

AHCCCS measured the percentage of newly placed HCBS members who received selected services within 30 days of enrollment. Examples of these services include adult day health care, attendant care, home-delivered meals, home health nursing and homemaker assistance.

Methodology

The study covered two measurement periods: October 1, 2001, through September 30, 2002, and October 1, 2002, through September 30, 2003. A representative random sample was selected for each Contractor. Data was first collected from AHCCCS encounter data. If services within 30 days of enrollment were not found in AHCCCS encounter data, contractors were asked to provide service delivery information from medical records, case management records or their claims data.

In analyzing the first study question (initiation of services within 30 days), AHCCCS excluded members who:

- refused services,
- were hospitalized during the first 30 days after enrollment,
- were receiving hospice services during the first 30 days after enrollment,
- were residing in an assisted living facility and thus receiving services, or
- could not be contacted after several attempts by the Contractor.

To validate additional information collected by contractors, AHCCCS required documentation of services provided or reasons why a member did not receive services (for example, the member refused services while waiting for a family member to become trained to provide attendant care or was hospitalized during all or part of the first 30 days of enrollment). Documentation provided by contractors included copies of the pertinent sections of case management records, medical/service records from providers or verification of claims paid by contractors for qualifying services.

The overall rate of initiation of services for the first measurement period was 83.5 percent and the overall rate for the second measurement period was 83.7 percent. Six of seven contractors exceeded the AHCCCS Minimum Performance Standard in the first measurement period and five contractors exceeded the standard for the second measurement period. Four contractors exceeded the Minimum Performance Standard in both periods.

Performance Improvement

By publishing this and other performance data, AHCCCS expects the timeliness of services to members to continue improving. AHCCCS requires corrective action plans from contractors who have not met Minimum Performance Standard for this measure in the most recent measurement period. As with other

performance measures, AHCCCS will work with contractors, especially those with the lowest rates, to assist them in improving their rates.

Performance Improvement Projects (PIPs)

In addition to Performance Measures, AHCCCS requires contractors to conduct Performance Improvement Projects (PIPs), as defined under BBA regulations. These PIPs are designed to achieve, significant improvement in quality of care that is sustained over time through ongoing measurements and intervention. PIPs may be conducted in clinical or non-clinical areas that are expected to have a favorable effect on member health outcomes and satisfaction.

Contractors design and conduct their own PIPs and are required to participate in at least one AHCCCS-mandated PIP. In CYE 2004, AHCCCS initiated a new PIP for acute-care contractors to improve childhood immunization rates. For ALTCS contractors AHCCCS initiated a new PIP to better manage co-morbid, or multiple diseases, among long-term care members in home and community-based settings.

AHCCCS also conducted re-measurement of performance for a PIP initiated in CYE 2002, which included all contractors. That PIP measures annual Hb A_{1c} testing and laboratory levels for members with diabetes. Re-measurement data show that overall rates for both acute-care and ALTCS contractors increased significantly from the baseline measurement. Among ALTCS plans, six of eight contractors showed statistically significant improvement in their rates of annual Hb A_{1c} testing, and five contractors showed statistically significant improvement in their rates of poorly controlled Hb A_{1c} levels. Among acute-care plans, four of seven contractors showed statistically significant improvement in their rates of annual Hb A_{1c} testing, and three contractors showed statistically significant improvement in their rates of poorly controlled Hb A_{1c} levels. AHCCCS will measure contractor performance in this PIP again next year.

Financial Viability Standards

AHCCCS has established financial and operational standards that all contractors must meet. Based on these standards, AHCCCS and the Health Plans examine profitability and administrative performance issues through an analysis of four financial viability standards. The following is a brief explanation of each standard and the Health Plan results of the most recent financial audits conducted.

Current Ratio

This standard measures whether a Health Plan can pay current obligations as they come due. Results show that all Health Plans were able to meet the standard.

Equity per member

This standard measures a Health Plan's ability to withstand adverse utilization over a one-year period. Results show that all but one Health Plan met this standard. This Health Plan came into compliance the following quarter.

Medical Expense Ratio

This standard shows how well a Health Plan manages care. If it is too low, under-utilization of services may be a problem. If it is too high, the Health Plan may be managing care inappropriately. All Health Plans met the medical loss ratio standard.

Administrative Cost Percentage

This standard measures the percentage of AHCCCS capitation premiums spent on non-medical expenses. All Health Plans but one met the administrative cost percentage standard. This Health Plan came into

compliance the following quarter. Typically the plans want to keep their administrative expenses low to show a profit, and therefore little incentive is needed to meet this standard.

Days Outstanding Received but Unpaid Claims

This standard shows if claims are being paid in a timely fashion. This standard may suggest cash flow problems if Health Plans are slow in paying bills. All Health Plans except two met this standard. The Health Plans that did not meet the standard both came into compliance for the following quarters to date..

In addition to the four financial viability standards mentioned above, AHCCCS monitors, on a minimum quarterly basis, the operating income or loss of the Health Plans as well as the Incurred but Not Reported (IBNR) claims estimates. The IBNR estimates the dollar amount of claims for which the Health Plan has provided the service but has not received the actual claim.

Grievance System

The AHCCCS' Office of Legal Assistance (OLA) provides legal assistance to program support and operates the agency's Grievance System, including scheduling State Fair Hearings and informal adjudication of member appeals and provider claim disputes.



During the last year, OLA received 10,733 matters, including member appeals, provider claims disputes, ALTCS trust reviews and eligibility appeals. OLA issued 3,275 Director's Decisions after State Fair hearings were held. OLA was able to resolve 7,079 cases at the informal level, alleviating the need for a State Fair Hearing.

Of the 10,733 total cases received by OLA, 953 were member appeals, 6,796 were provider claims disputes, 677 were ALTCS trust reviews and 2,307 were eligibility appeals.

Fraud and Abuse

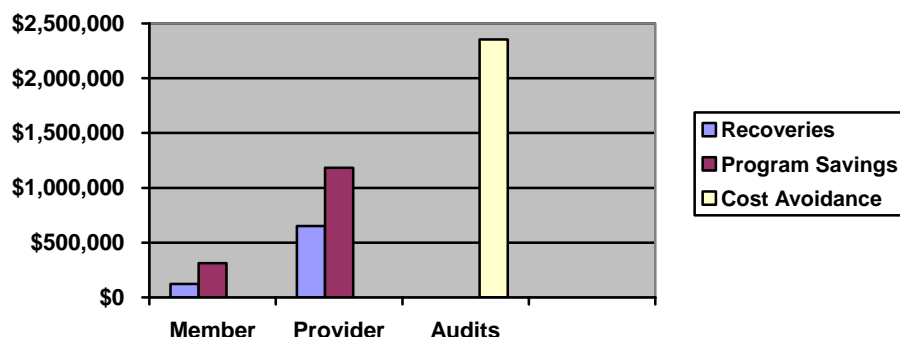
The AHCCCS Office of Program Integrity (OPI) is responsible for combating fraud and abuse in the Arizona Medicaid program. OPI consists of three Units; Audits, Member Fraud and Provider Fraud. OPI has developed a comprehensive approach that focuses on strengthening program safeguards, assessing areas of potential vulnerability and investigating allegations of fraud and abuse.

OPI visited AHCCCS Contractors on-site to discuss the development of formal compliance programs. In light of the new requirements and to promote development of effective compliance programs over the next year, OPI, in coordination with the Division of Health Care Management, has strengthened contracts by requiring the formation of Compliance Committees and written criteria for selecting a Compliance Officer. OPI also participates in all the scheduled Operational and Financial Reviews to further strengthen the Fraud Waste and Abuse program. The AHCCCS fraud and abuse policy was revised in October 2003 to incorporate the requirement for Compliance Officers and the reporting of potential/suspected fraud and abuse within 10 working days of the discovery of the incident.

OPI continues to host fraud and abuse work group meetings, now called "Compliance Officer Network Group" meetings. Subjects include program safeguards designed to limit abuse and diversion of prescription drugs by AHCCCS members and discussions on any methods to strengthen and improve efforts to prevent, detect and report fraud and abuse in the State's Medicaid Program. Additionally, the Director of Program Integrity and the Director of the Medicaid Fraud Control Unit of the Attorney General's Office have conducted several joint fraud awareness presentations to AHCCCS Contractors.

Two audits were completed in 2004 on “Durable Medical Equipment Rental Versus Purchase” and “Durable Medical Equipment Small Volume Nebulizers.” The Audit Unit routinely utilizes the “Medicare Fraud Alerts” to determine if the AHCCCS program is vulnerable to schemes outlined in the Alerts.

Chart 5C
Provider Fraud Unit Activity



OPI and the Attorney General’s Office recently concluded a complex investigation of major fraud by a provider. On July 22, 2004, defendant Paul Pramoj was found guilty in Cochise County Superior Court of one count of Fraudulent Schemes and Aftifices, two counts of Theft, two counts of Money Laundering and three counts of Forgery. Under Arizona State law, the penalty range for the defendant’s offenses is a minimum of three years to a maximum of 12.5 years imprisonment. He is scheduled for sentencing in December 2004.

A major investigation with the Health and Human Services, Office of Inspector General and the Arizona Attorney General’s Office was concluded in July 2004. The suspect was indicted on 12 felony counts of Fraudulent Schemes and Aftifices, Theft, Attempted Theft and Forgery totaling \$769,797.00. The trial relating to this investigation is scheduled for December 2004.

Financial and Operational Reviews

AHCCCS requires that all Health Plans, Program Contractors and ADHS and its subcontracted RBHAs adhere to standards expressly stated in their contract with AHCCCS. Health Plans, Program Contractors and RBHAs may not prosper by underserving enrolled members. Therefore, each Health Plan, Program Contractor and RBHA must:

- Disclose ownership and related third party transactions;
- Post performance bonds for insolvency protection;
- Prepare contingency plans in the event of insolvency;
- Meet stringent financial management standards established by AHCCCS; and
- Contract for an annual certified audit performed by a certified public accountant.

AHCCCS completes operational and financial reviews of Health Plans, Program Contractors and ADHS Behavioral Health Services. These site visits review contractors’ general administration, including:

- Business continuity plans;
- Cultural compliance;
- Staffing;
- Corporate compliance;
- Quality management processes, including provider credentialing;
- Handling of quality of care issues and complaints;
- Care coordination and case management processes;

- The delivery of maternal and child health services;
- The grievance system;
- The delivery system;
- Member services;
- Reinsurance;
- Finances;
- Claims processing and payment;
- Encounter processing and submission; and
- Behavioral health coordination.

Teams representing various AHCCCS divisions perform the reviews. This integrated approach allows AHCCCS to maintain a comprehensive understanding of contractor activities, ensure effective contract compliance and delivery of services to members and in the event of deficiencies, provide technical assistance to resolve the problem and ensure that it will not reoccur.

CHAPTER 6

EVALUATIONS OF THE AHCCCS PROGRAM

AHCCCS has been evaluated by the Arizona Legislature, private firms, federal agencies, such as the General Accounting Office (GAO), and contractors hired by CMS to evaluate the AHCCCS acute care, ALTCS and KidsCare programs. The majority of reports issued by these organizations have been generally positive and have praised various components of the program. The evaluations also contained suggestions for improvements that have helped AHCCCS to make adjustments where necessary.

Another important measurement for CMS and other observers was the overall cost of the AHCCCS program when compared with traditional FFS programs in other states and the quality of care provided by the Nation's first statewide managed care program. The following reports, evaluations and surveys reinforce that managed care constrains costs without sacrificing quality of care.

1995 GAO Report

The GAO report in 1995 stated that Arizona's Medicaid program, operating under a waiver from certain federal requirements, has succeeded in containing costs while providing beneficiaries access to what State officials and health providers describe as mainstream medical care. Arizona's AHCCCS program can serve as a model for other Medicaid programs. Rapid escalation in Medicaid costs has prompted many states to search for new ways to control spending, including moving more beneficiaries into managed care delivery systems. No state, however, is as advanced as Arizona in using market forces to control cost growth. Although each state Medicaid program is unique, states converting from a FFS to a managed care program can learn from Arizona's experience.

Auditor General Report

Published in the last quarter of the federal fiscal year, the Arizona Auditor General reported results of five reports conducted during the year. Four Performance Audits were conducted measuring Medical Services Contracting, Division of Member Services, Rate Setting Procedures and Quality of Care. The fifth audit, the Sunset Review, provides information about the 12 Sunset Factors the Legislature is to consider in determining whether to continue the Arizona Health Care Cost Containment System (AHCCCS).

The Legislative Reference Committee responsible for recommending extension of the agency unanimously approved recommending that AHCCCS be extended for another 10 years.

The Committee not only recommended that the agency be continued, but also added a formal commendation to the agency for our good work at serving the public. The next step is for legislation to be introduced in both the House and Senate to extend AHCCCS for 10 years. The report indicates a continued need for AHCCCS, notes that AHCCCS has met its overall objective and purpose and summarizes the four performance audits conducted on AHCCCS that identify opportunity for improvement.

Recognition

AHCCCS has received numerous commendations and awards over the years. Some of these include the Leadership Award for Medical Quality from the American College of Medical Quality, a Health Care Financing Association (HCFA) National Customer Service Award for collaboration with the Native Americans, the Council of State Government Award for Eligibility Fraud Prevention Program and Health Affairs cited AHCCCS as one of the few prudent purchasers of health care in the nation.



ACUTE CARE EVALUATIONS

Laguna Research Associates' Final Report, published in February 1996, included the following findings for the acute care program:

- Review of the mature AHCCCS acute care program (years 6-11) indicates continued success for the program.
- Cost savings are increasing, the market place is getting more competitive, utilization of services is appropriate and management information system development has stabilized.

As Americans today look for ways to rationalize the delivery of medical care services, capitation appears to demonstrate one viable option. Findings from the evaluations of the AHCCCS programs have indicated success in delivering services statewide to Medicaid eligibles of all eligibility groups.

In July 1996, the **Kaiser Family Foundation** produced *The Arizona Health Care Cost Containment System: Thirteen Years of Managed Care in Medicaid* which was based on CMS contracted reports produced by Stanford Research Institute (SRI) and Laguna Research Associates. The report highlights areas where states which are implementing programs similar to the AHCCCS acute care program and ALTCS program should focus their attention.

Two of the findings of the report were:

- The experience of AHCCCS demonstrates that capitated Medicaid can be successful in providing high quality, accessible care of costs lower than traditional Medicaid to beneficiaries of all eligibility groups in both urban and rural areas.
- AHCCCS saves money overall even though its administrative costs are higher; states should look beyond the initial investment and higher operating expenses toward future overall cost savings and more effective program management.

The cost effectiveness of the AHCCCS program has been well documented, but less systematic research has been done on quality of care, including members' satisfaction with the program. To make sure that Health Plans are evaluated on other factors in addition to cost, AHCCCS places a high priority on quality monitoring. In an effort to determine the quality of acute care from the perspective of AHCCCS members, AHCCCS conducted telephone interviews of more than 14,000 members to gather information for the first general member survey of its type, the 1996 Member Satisfaction Survey.

The survey provided considerable insight into member satisfaction as evidenced by the following results:

- 75 percent of respondents gave a rating of "good" or "very good" in six areas that were identified to summarize the overall quality rating of the program.
- Office nurses and primary care providers were viewed by the respondents as being the most courteous and respectful with 89 percent of respondents giving the highest rating.
- Over 87 percent of the respondents rated the availability of appointments, whether for checkups or illness, as being satisfactory or very satisfactory.

ALTCS EVALUATIONS

The success of the ALTCS program rests principally on the cost effectiveness of HCBS and an effective PAS process that ensures persons who become eligible for ALTCS are at risk of institutionalization.

In 1992, William Weissert, Ph.D. completed a CMS-funded evaluation of HCBS cost-effectiveness in the ALTCS program. As a result of the Weissert study, CMS removed the HCBS cap on enrollment. However, as a condition of removing the HCBS cap 1997/98, AHCCCS was required to conduct a cost-effectiveness study of HCBS as a follow-up to the earlier study. As anticipated by AHCCCS, Dr. Weissert's conclusions were the same in 1998 as they had been in 1992.

- The ALTCS program appears to be maintaining eligibility standards at about the level they were during the program's early years. This analytical approach demonstrated cost-effectiveness then and it again shows cost-effectiveness now.
- In spite of the fact that a higher HCBS cap is in place, the present study did not find evidence to support the assumption of a woodwork effect large enough to offset savings from substitutions of HCBS for nursing facility care.

The Final Report completed by Laguna Research Associates in February 1996 summarized their evaluations of the AHCCCS program by saying:

- In summary, both the AHCCCS acute care program and ALTCS seem to be successful in producing cost savings.
- Cost of the program as compared to a traditional Medicaid program is 7 percent less per year for the acute care program averaged over the first 11 years of the program, and 16 percent less per year for the long-term care program for its first five years.

A historical snapshot for each year of the AHCCCS program from 1982 to present is available in Appendix V. Each year displays the highlights and major program and administrative changes for the acute care, ALTCS, KidsCare and other AHCCCS programs. Expenditures figures by funding source and 1115 waiver highlights are also provided in Appendix IV.

SURVEYS

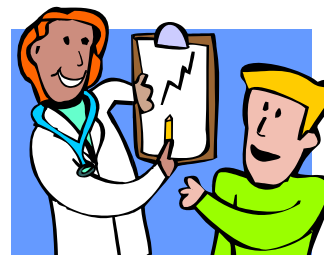
Member Satisfaction Surveys



In January 1999, AHCCCS began the development of the 2000 Member Satisfaction Survey to evaluate and improve health care delivered through its contracted Health Plans. AHCCCS used the Consumer Assessment of Health Plan Survey (CAHPS) instrument and methodology for this survey so that results could be compared to national averages to better determine areas of excellence and those requiring improvement. Although CAHPS is largely a standardized survey, there was some customization that enabled it to cover areas of interest to AHCCCS and its members. The survey focused primarily on member satisfaction with Health Plans, personal doctor or nurse, specialists, health care received and dental care received.

Results:

- Respondents rated their Health Plan substantially higher than the national average.
- Respondents rated the health care they received considerably higher than the national average.
- More than three-fourths of the respondents reported it was “not a problem” to find a personal doctor or nurse that they were happy with.



- More than 85 percent of the respondents reported that their doctor understood how any of their health problems affected them.
- 81 percent of the respondents reported that they “usually” or “always” got an appointment within their desired timeframe.

Provider Satisfaction Surveys

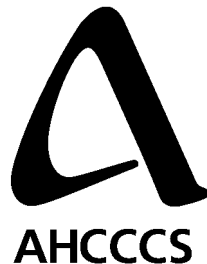
In 1998, AHCCCS conducted the first phase of the Provider Satisfaction Survey by collecting feedback from physicians and office managers in primary care and specialty practices. The survey covered a broad range of topics including the contracting process, reimbursement, policies and procedures, utilization management, provider education and communication, quality management and claims payment. AHCCCS uses the survey information in its contracting and oversight activities and as a baseline component of the Quality Improvement Initiative.

The second phase of the Provider Satisfaction Survey was a Dentists' Assessment. The survey covered a similar range of topics with the addition of a section about dentists' reactions to recent program changes. Fieldwork for this survey was conducted during the summer of 1999 and a final report was released at the end of 1999. As with the physician and office manager assessments, results are used as a part of the Quality Improvement Initiative.

TOP SIX ACCOMPLISHMENTS AT AHCCCS DURING RECENT YEARS

1. **KidsCare.** This program, part of the national Children's Health Insurance Program (CHIP), was implemented under AHCCCS during this time and has made it possible for some 150,000 Arizona children to receive health care. Of these, some 100,000 children whose parents applied through KidsCare were poor enough to qualify for the regular AHCCCS program. The remaining 50,000 were categorized as KidsCare children. All children, regardless of which program they joined, receive the same care because it is all delivered through the AHCCCS system of Health Plans. The income limit is set at 200 percent of the federal poverty level, or \$3,142 a month for a typical family of four.
2. **Proposition 204.** This proposition was passed by Arizona voters in 2000 and was implemented under AHCCCS a year later. It raised eligibility limits for some categories under AHCCCS and has made it possible for about 88,000 more residents to receive health care. AHCCCS eligibility categories that had income limits below the federal poverty level were raised to that level and those above the poverty level – such as KidsCare and SOBRA pregnant women – were not affected. The federal poverty level for an individual is currently \$776 per month and for a family of four it is \$1,571 a month. Implementation of Prop. 204 required an extensive commitment of resources at the agency, but implementation went smoothly and the program has been a significant success.
3. **HAPA, the Hawaii project.** Governor Hull approved a first-ever project between Arizona and Hawaii that allowed the two states to share database information and resources, thereby providing better service to the people of each state. HAPA stands for Hawaii and Arizona PMMIS Alliance. The PMMIS (Prepaid Medical Management Information System) is AHCCCS' massive computer system designed specifically for Arizona's managed-care Medicaid program. Under the agreement, Hawaii would be able to use the PMMIS for its own Medicaid program and bear most of the expense of the project, also sharing the cost of improvements to the system.

4. **Web Technology.** Two major projects fall under this category: The Health-e-Arizona project and the Provider Web Project. Health-e-Arizona is a paperless, electronic interview pilot project that provides real-time eligibility screening. It offers English and Spanish versions in an application that is fully compliant with ADA. It is a partnership between AHCCCS, DES and the Community Health Centers Collaborative Ventures and the pilot operates out of El Rio Health Center locations in Tucson, DES offices in Pima County and the AHCCCS SSI/MAO and KidsCare offices in Phoenix. The Provider Web Project is a pilot project using a website that allows AHCCCS providers to verify member eligibility and enrollment electronically. It is yet another alternative providers can use for eligibility verification rather than calling by telephone.
5. **Quality Initiative.** The AHCCCS Quality Initiative effort is in conformance with Governor Hull's effort to establish a statewide strategic plan to set a policy agenda, specific goals and performance measures for the entire executive branch. The agency further developed its strategic planning effort and quality initiatives in an effort to develop a disciplined approach to the way the agency does business, using tools that are universally understood so the agency's outputs could achieve a greater level of quality. Various aspects of this quality effort have been recognized locally and nationally including:
 - The American College of Medical Quality selected AHCCCS as recipient of the 2000 Institutional Leadership in Quality Award.
 - The Council of State Governments recognized AHCCCS' fraud prevention program with its Innovation Award.
 - The AHCCCS Native American coordinator won both the Tucson Area IHS Director's Merit Award and the HCFA (now CMS) customer service award.
 - Additionally, two AHCCCS projects received 2002 Governor's Spirit of Excellence Awards.
6. **Improved Immunization Rates.** The monitoring of AHCCCS immunization rates is critical to identify undervaccinated populations and increase coverage levels, both in children and adults. For children, nine of 10 immunizations evaluated by AHCCCS and recommended by the Centers for Disease Control Prevention have shown improvement. They include immunizations for diphtheria, tetanus, measles, mumps and rubella, among others. Immunizations and pneumococcal vaccination under the Arizona Long Term Care System also have shown improvement. All seven ALTCS Program Contractors attained rates above the AHCCCS performance standard (APB) for influenza immunizations in HCBS settings, and six obtained ratings above the APB in nursing facility settings. For pneumococcal vaccinations, six contractors were above the APB in HCBS settings and five attained this rating.





AHCCCS ELIGIBILITY REQUIREMENTS April 1, 2004

Where to Apply	Eligibility Criteria				General Information
	Household Monthly Income by Household Size (After Deductions) ¹	Resource Limits (Equity)	Social Security #	Special Requirements	Benefits

Coverage for Children

S.O.B.R.A. Children < 1	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Child living alone Child living with 1 parent 1/2 of Child living with 2 parents 1/3 of	\$1,087 \$1,458 \$1,829	N/A	Required	N/A	AHCCCS Medical Services ³
S.O.B.R.A. Children 1 - 5	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Child living alone Child living with 1 parent 1/2 of Child living with 2 parents 1/3 of	\$1,032 ² \$1,385 \$1,737 ²	N/A	Required	N/A	AHCCCS Medical Services ³
S.O.B.R.A. Children >6 <19	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Child living alone Child living with 1 parent or spouse 1/2 of Child living with 2 parents 1/3 of	\$ 776 ² \$1,041 \$1,306	N/A	Required	N/A	AHCCCS Medical Services ³
KidsCare Children < 19	Mail to KidsCare 920 E. Madison, MD 500 Phoenix, Arizona 85034	1 \$1,552 2 \$2,082 3 \$2,612 4 \$3,142 Add \$530 per Add'l person		N/A	Required	<ul style="list-style-type: none"> Not eligible for Medicaid No health insurance coverage within last 3 months Not available to State employees, their children, or spouses \$20-35 monthly premium covers all eligible children 	AHCCCS Medical Services ³

Coverage for Families or Individuals

AHCCCS for Families with Children	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	1 \$ 776 2 \$1,041 3 \$1,306 4 \$1,571 Add \$256.66 per Add'l person		N/A	Required	<ul style="list-style-type: none"> Family includes a child deprived of parental support due to absence, death, disability, unemployment or underemployment 	AHCCCS Medical Services ³
AHCCCS Care (AC)	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Applicant living alone \$ 776 ² Applicant living with spouse 1/2 of \$1,041		N/A	Required	<ul style="list-style-type: none"> Ineligible for any other categorical Medicaid coverage 	AHCCCS Medical Services ³
Health Insurance for Parents	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office or Mail to KidsCare 920 E. Madison, MD 500 Phoenix, Arizona 85034	1 \$1,552 2 \$2,082 3 \$2,612 4 \$3,142 Add \$530 per Add'l person		N/A	Required	<ul style="list-style-type: none"> Ineligible for any categorical Medicaid coverage Parent living with a child who is eligible under S.O.B.R.A. or KidsCare. No health insurance coverage within last 3 months Not for State employees, their children, or spouses \$15-\$25 monthly premium for each covered parent Enrollment is limited 	AHCCCS Medical Services ³
Medical Expense Deduction (MED)	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	1 \$ 310 2 \$ 417 3 \$ 523 4 \$ 629 Add \$106 per Add'l person	\$100,000 No more than \$5,000 liquid		Required	<ul style="list-style-type: none"> Ineligible for any other Medicaid coverage. May deduct allowable medical expenses from income 	AHCCCS Medical Services ³

Coverage for Women

S.O.B.R.A. Pregnant	DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	For a pregnant woman expecting one baby: Applicant living alone \$1,385 Applicant living with: 1 parent or spouse 2/3 of \$1,737 Applicant living with 2 parents 1/2 of \$2,090 (Limit increases for each expected child)		N/A	Required	Need proof of pregnancy	AHCCCS Medical Services ³
Breast & Cervical Cancer Treatment Program	Well Women Healthcheck Program Call 1-888-257-8502 for the nearest office	N/A		N/A	Required	<ul style="list-style-type: none"> Under age 65 Screened and diagnosed with breast cancer, cervical cancer, or a pre-cancerous cervical lesion by the Well Woman Healthcheck Program Ineligible for any other Medicaid coverage 	AHCCCS Medical Services ³

AHCCCS ELIGIBILITY REQUIREMENTS April 1, 2004



Application	Eligibility Criteria				General Information
Where to Apply	Household Monthly Income by Household Size (After Deductions) ¹	Resource Limits (Equity)	Social Security Number	Special Requirements	Benefits

Coverage for Elderly or Disabled People

Long Term Care	ALTCS Office Call 602-417-7000 or 1-800-654-8713 for the nearest office	\$1,692 Individual	\$2,000 Individual ⁴	Required	<ul style="list-style-type: none"> Requires nursing home level of care or equivalent May be required to pay a share of cost Estate recovery program for the cost of services received after age 55 	AHCCCS Medical Services ³ , Nursing Facility, Home & Community Based Services, and Hospice
SSI CASH	Social Security Administration	\$ 564 Individual \$ 846 Couple	\$2,000 Individual \$3,000 Couple	Required	<ul style="list-style-type: none"> Age 65 or older, blind, or disabled 	AHCCCS Medical Services ³
SSI MAO	Mail to SSI MAO 1209 E. Washington, MD 400 Phoenix, Arizona 85034	\$ 776 Individual \$1,041 Couple	N/A	Required	<ul style="list-style-type: none"> Age 65 or older, blind, or disabled 	AHCCCS Medical Services ³
Freedom to Work	Mail to: 701 E. Jefferson MD 7004 Phoenix, AZ 85034 602-417-6677 1-800-654-8713 Option 6	\$1,940 Individual Only Earned Income is Counted	N/A	Required	<ul style="list-style-type: none"> Must be working and either disabled or blind Must be age 16 through 64 Premium may be \$0 to \$35 monthly <p>+ Need for Nursing home level of care or equivalent is required for Long Term Care (Nursing Facility, Home & Community Based Services, or Hospice)</p>	AHCCCS Medical Services ³ Nursing Facility, Home & Community Based Services, and Hospice

Coverage for Medicare Beneficiaries

QMB	Mail to SSI MAO 1209 E. Washington, MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	\$ 776 Individual \$1,041 Couple	N/A	Required	<ul style="list-style-type: none"> Entitled to Medicare Part A 	Payment of Part A & B premiums, coinsurance, and deductibles
SLMB	Mail to SSI MAO 1209 E. Washington, MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	\$ 776.01 – \$ 931 Individual \$1,041.01 – \$1,249 Couple	N/A	Required	<ul style="list-style-type: none"> Entitled to Medicare Part A Not receiving Medicaid benefits 	Payment of Part B premium
QI-1	Mail to SSI MAO 1209 E. Washington, MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	\$ 931.01 – \$1,048 Individual \$1,249.01 – \$1,385 Couple	N/A	Required	<ul style="list-style-type: none"> Entitled to Medicare Part A Not receiving Medicaid benefits 	Payment of Part B premium
QDWI	Mail to SSI MAO 1209 E. Washington, MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	\$1,552 Individual \$2,082 Couple	\$4,000 Individual \$6,000 Couple	Required	<ul style="list-style-type: none"> Entitled to enroll in Medicare Part A Not receiving Medicaid benefits 	Payment of Part A premium

NOTE: Applicants for the above programs must be Arizona residents and either U.S. citizens or qualified immigrants.

Applicants for S.O.B.R.A., AF Related, AC, MED, SSI-MAO, and Long Term Care who do not meet the citizen/immigrant status requirements may qualify for Emergency Services.

¹ Income deductions vary by program, but may include work expenses, child care, and educational expenses.

² Income considered is the applicant's income, a share of the parent's income, and a share of the spouse's income.

³ AHCCCS Medical Services include, but are not limited to, doctor's office visits, immunizations, hospital care, lab, x-rays, and prescriptions.

⁴ If the applicant has a spouse living in the community, between \$18,552 and \$92,760 of the couple's resources may be disregarded.

APPENDIX II

AHCCCS ENROLLMENT, 1982 – 2004

DATE	1931 and 1931/ MAO	SSI and SSI/ MAO	KIDSCARE	SOBRA Kids	SOBRA Moms	SES	FES	FPS	QMB ONLY	AHCCCS Care	MED	Breast and Cervical	CMP	MN/MI	EAC	ELIC	ALTCS	TOTAL
12/6/82*	53,195	28,322												8,166				89,683
12/15/83*	66,520	29,506												51,098				147,124
7/1/84	74,898	30,582												79,929				185,409
7/1/85	71,948	32,340												40,162				144,450
7/1/86	74,043	34,869												42,234				151,146
7/1/87	88,059	36,949												47,003	19,161	1,133		192,305
7/1/88	100,014	38,760		4,139	1,694									47,680	22,613	1,525		216,425
7/1/89	118,989	36,698		23,031	5,799									44,626	35,958	3,690	9,308	278,099
7/1/90	143,480	38,828		45,432	8,843									40,176	26,135	3,109	12,380	318,383
7/1/91	178,112	43,692		63,631	10,143									40,347	23,540	3,724	14,019	377,208
7/1/92	209,472	49,726		77,858	10,486									48,787	21,988	5,018	16,070	439,405
7/1/93	217,845	56,055		91,139	11,265								14,127	49,201	5,305	5,162	17,560	467,659
7/1/94	220,568	61,316		99,721	11,480	276	3,437						14,108	31,314	1,755	557	18,808	463,340
7/1/95	208,325	66,006		98,662	11,565	283	4,352						9,410	30,179	1,914	530	20,361	451,587
7/1/96	206,959	69,425		104,570	12,358	349	5,048	12,675	5,219				5,186	29,819	2,158	489	21,862	476,117
7/1/97	184,943	69,742		106,539	12,192	225	5,021	23,213	5,586				1,098	26,147	1,603	404	23,479	460,192
7/1/98	145,156	72,131		117,545	12,383	235	4,365	23,831	6,080					22,801	1,014	445	25,061	431,047
7/1/99	132,245	73,317	14,985	138,331	12,760	234	5,521	22,030	6,782					21,083	230	187	26,860	454,565
7/1/00	160,213	75,128	35,034	148,480	11,799	189	7,077	21,247	7,559					17,686	254	114	29,031	513,811
7/1/01	256,988	85,628	52,100	112,945	9,874	117	8,661	19,619	834					22,297	196	165	31,994	601,418
7/1/02	427,314	93,651	49,027	72,564	8,817	376	9,360	9,650	876	77,481	3,836	11					34,665	786,763
7/1/03	496,253	102,348	51,027	73,119	8,789		53,559	7,056	860	103,169	3,709	34					37,465	937,388
7/1/04	487,956	109,390	49,967	70,790	8,733		65,644	7,258	1,011	98,889	3,714	66					39,152	942,570

* December was the only month for which figures were available for these two years.

Source: Divisions of Member Services Enrollment Reports, except 1982 figures which came from the 1983 waiver document.

Appendix III

COVERED SERVICES

The following definitions apply:

- **EPD** means the elderly and physically disabled population under ALTCS.
- **DD** means the developmentally disabled population under ALTCS.

ACUTE CARE SERVICES

- Inpatient and outpatient hospital services
- Outpatient health services, including those services that may be provided in a Rural Health Clinic or Federally Qualified Health Center
- Laboratory, X-ray and medical imaging services
- Nursing facility services in lieu of hospitalization not to exceed 90 days per contract year
- Physician services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under the age of 21. These include all medically necessary Title XIX services.
- Family planning services, including drugs, supplies, devices and surgical procedures provided to delay or prevent pregnancy
- Preventative, Therapeutic and Emergency services and medically necessary dentures for members under the age of 21. Emergency services and medically necessary dentures for members age 21 and over
- Nurse-midwife and nurse practitioner services
- Home health services provided in lieu of hospitalization
- Emergency ambulance transportation and medically necessary transportation services
- Emergency room services
- Other licensed practitioner services, including respiratory therapists, physician assistants, certified nurse anesthetists, licensed midwives (for members age 21 and over) and non-physician behavioral health professionals
- Prescribed drugs
- Medical supplies, durable medical equipment, and prosthetic and orthotic devices
- Therapies, which include physical, occupational, audiology and speech therapies. Occupational and speech therapy in the outpatient setting is limited to members under the age of 21 for acute members. No limitation for ALTCS members
- Podiatry services
- Private duty nursing services, if medically necessary

Appendix III

- Non-experimental Transplants approved for Title XIX reimbursement
- Optometrist services
- Eyeglasses and contact lenses for members 21 years and older as the sole external prosthetic device after a cataract extraction
- Home health therapy services
- Screening, diagnostic, rehabilitative and preventive services for members 21 years and older

ACUTE CARE BEHAVIORAL HEALTH SERVICES

Covered behavioral health services include:

- Inpatient hospital services
- Inpatient psychiatric facility (residential treatment centers and sub-acute facilities)
- Out patient services
- Individual therapy and counseling
- Group and/or family therapy and counseling
- Psychotropic medication adjustment and monitoring
- Partial care (supervised day program, therapeutic day program and medical program)
- Emergency behavioral health services
- Clinic services
- Institution for Mental Disease (with limitations)
- Behavior management (behavioral health personal assistance, family support, peer support)
- Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)
- Screening
- Evaluation and diagnosis
- Case Management services
- Psychotropic medications
- Laboratory and radiology services for psychotropic medication diagnosis and regulation
- Transportation (emergency and non-emergency)
- Respite care (with limitations)
- Therapeutic Foster Care Services

Appendix III

KIDSCARE COVERED SERVICES

KidsCare members are eligible for the same services covered for members under the Acute Title XIX program.

ALTCS SERVICES

Covered ALTCS services include the all the acute care services and the following services.

- Nursing facility services
- Case management
- Speech, physical and occupational therapies
- Respiratory care services for ventilator dependent persons
- Services provided in Christian Science Sanitoria
- Hospice
- Adult Day Health (EPD only)
- Intermediate Care Facility for Mentally Retarded (DD only)
- Developmentally Disabled Day Care (DD only)
- Home Delivered Meals (EPD only)
- Home Health Agency services, including nursing services and home health aid
- Homemaker
- Personal Care
- Respite Care
- Habilitation
- Group Respite services as an alternative to Adult Day Health (EPD only)
- Attendant care services
- In home private duty nursing services
- Environmental Modifications
- Life Line Alert
- Supported Employment
- Other services, if approved by CMS and the Director of AHCCCS
- Services provided in the following settings:
 - Adult Foster Care Home

Appendix III

- Assisted Living Home
- Assisted Living Center (choice of Single Occupancy)
- Center for Traumatically Brain Injured
- DD Group Home
- Adult Developmental Home
- Child Developmental Foster Home
- Level I Behavioral
- Level II Behavioral
- Level III Behavioral

ALTCS BEHAVIORAL HEALTH SERVICES

- Inpatient hospital services
- Inpatient psychiatric facility (residential treatment centers and sub-acute facilities)
- Institution for Mental Diseases (with limitations)
- Individual therapy and counseling
- Group and/or family therapy and counseling
- Emergency behavioral health services
- Evaluation and diagnosis
- Screening
- Psychotropic medications, medication adjustment and monitoring
- Partial care (supervised day program, therapeutic day program and medical day program)
- Behavior management (behavioral health personal assistance, family support, peer support)
- Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)
- Transportation (emergency and non-emergency)
- Respite Care (with limitations)
- Therapeutic Foster Care Services
- Behavioral health case management services (limited)
- Laboratory and Radiology services for psychotropic medication regulation

Appendix III

APPROVED ALTCS SETTINGS

INSTITUTIONAL SETTINGS

- Nursing Facilities (NFs)
- Institutional Care Facilities/Mentally Retarded (ICFs/MR)
- Hospice
- Residential Treatment Centers, inpatient psychiatric hospitals. Level I sub-acute facilities
- Institution for Mental Disease (IMD) for individuals under age 21 or age 65 and over
- IMDs, for person age 21 through 64 for 30 days per admission and 60 days per year

APPROVED HCBS SETTINGS FOR ELDERLY AND PHYSICALLY DISABLED

- Adult Foster Care
- Own Home (as defined by rule)
- Hospice
- Approved Alternative Settings:
 - Level II and Level III Behavioral Health Service Agency
 - Rural Substance Abuse Agency
 - Group Home for Traumatic Brain Injured members enrolled with ALTCS and approved by AHCCCS on a case by case basis
 - Assisted Living Home
 - Assisted Living Center (choice of Single Occupancy)
 - Alzheimer's Treatment Assistive Living Facilities (Pilot)
 - Adult Therapeutic Foster Home
 - DES/DDD Group Home
 - Adult Developmental Home
 - Child Developmental Foster Home

APPROVED HCBS SETTINGS FOR DEVELOPMENTALLY DISABLED

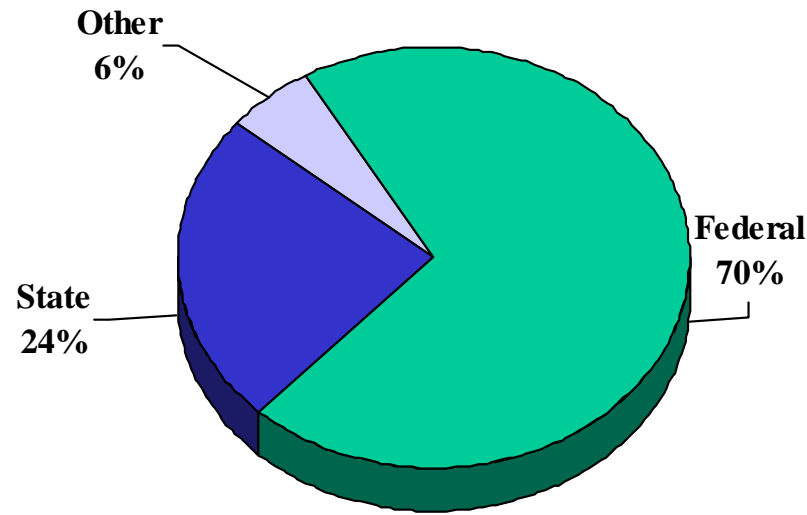
- Home
- Hospice
- DES/DDD Group Home
- Adult Developmental Home
- Child Developmental Foster Home

Appendix III

- Level II or Level III Behavioral Health Service Agency
- Rural Substance Abuse Transitional Agency
- Group Home for Traumatic Brain Injured members enrolled with ALTCS and approved by AHCCCS on a case by case basis
- Assisted Living Home
- Assisted Living Center (choice of Single Occupancy)
- Adult Therapeutic Foster Home

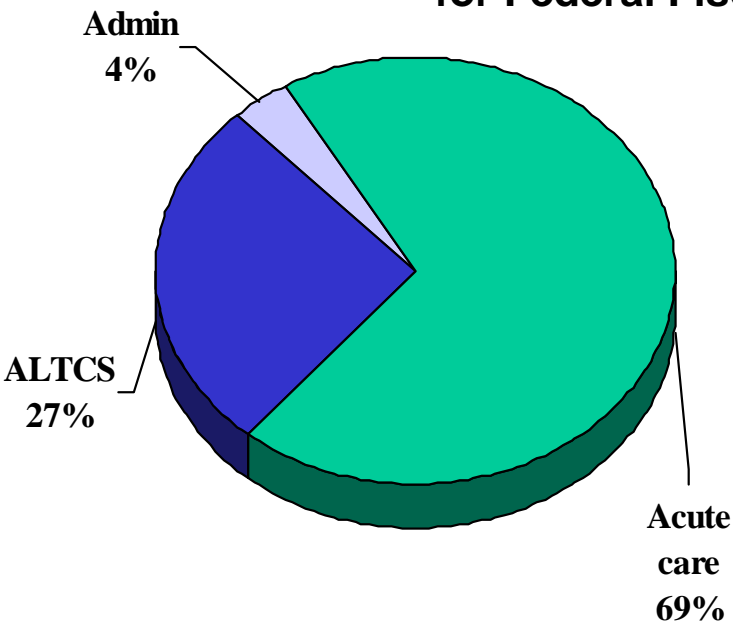
APPENDIX IV

Title XIX Expenditures by Funding Source for Federal Fiscal Year 2004



<u>Funding Source</u>	<u>Amount</u>
Federal	\$3,603,089,958
State	1,232,292,347
Other	<u>287,042,908</u>
Total	\$5,122,425,213

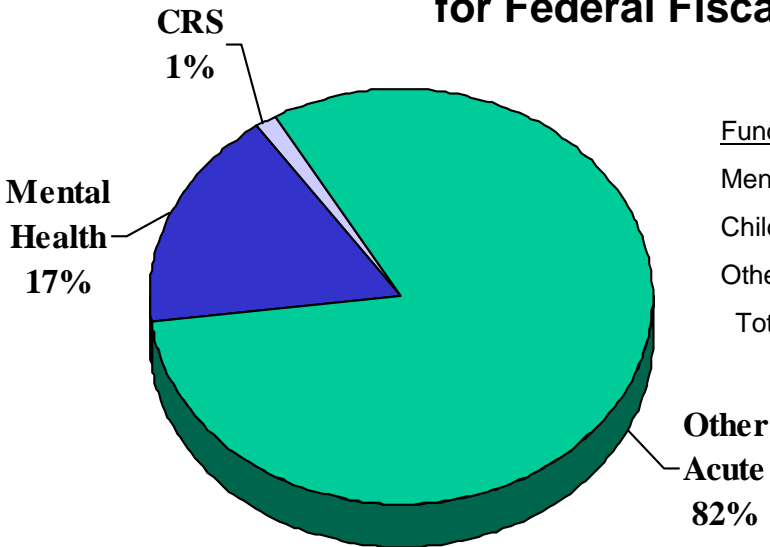
Title XIX Expenditures by Program Type for Federal Fiscal Year 2004



<u>Program Type</u>	<u>Amount</u>
Acute care	\$3,559,139,369
ALTCS	1,373,828,966
Administrative	<u>189,456,878</u>
Total	\$5,122,425,213

APPENDIX IV

Title XIX Acute Care Expenditures by Type for Federal Fiscal Year 2004



Funding Source	Amount
Mental Health	\$618,898,719
Children's Rehabilitative Services (CRS)	46,000,156
Other Acute	<u>2,894,240,494</u>
Total	\$3,559,139,369

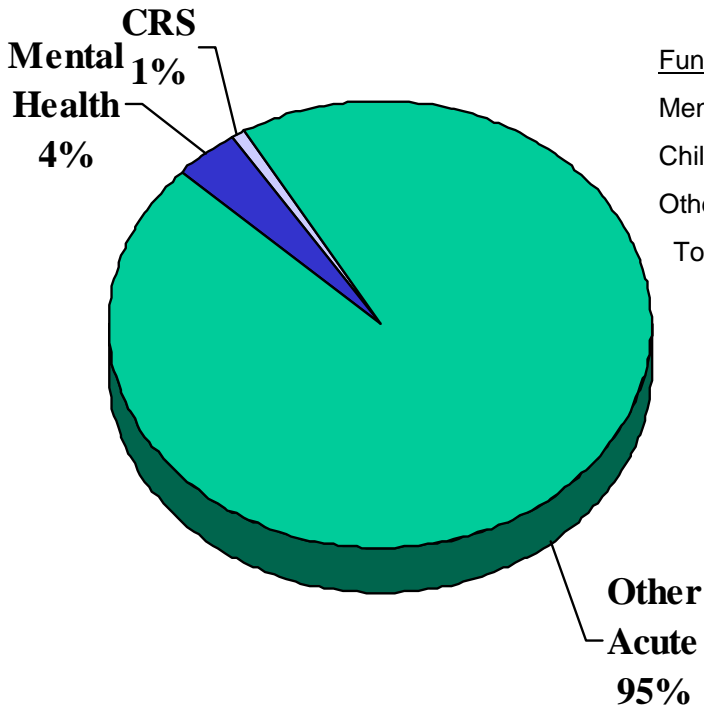
Title XIX ALTCS Expenditures by Type for Federal Fiscal Year 2004



Program Type	Amount
Developmentally Disabled	\$528,306,478
Elderly/Physically Disabled	<u>845,522,488</u>
Total	\$1,373,828,966

APPENDIX IV

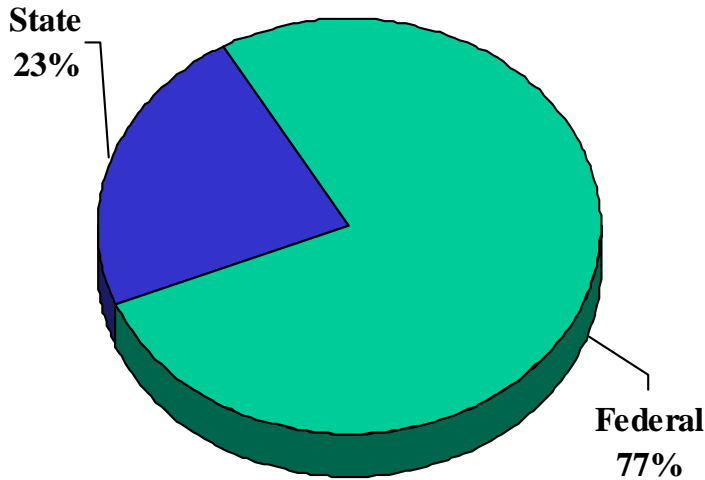
Title XXI Acute Care Expenditures by Type for Federal Fiscal Year 2004



<u>Funding Source</u>	<u>Amount</u>
Mental Health	\$12,378,529
Children's Rehabilitative Services (CRS)	3,156,383
Other Acute	<u>313,098,556</u>
Total	\$328,633,468

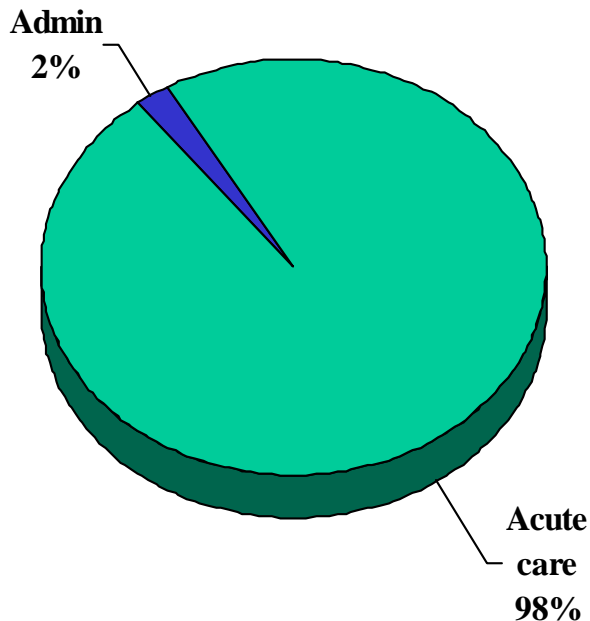
APPENDIX IV

Title XXI Expenditures by Funding Source for Federal Fiscal Year 2004



<u>Funding Source</u>	<u>Amount</u>
Federal	\$258,894,945
State	<u>76,936,305</u>
Total	\$335,831,250

Title XXI Expenditures by Program Type for Federal Fiscal Year 2004



<u>Program Type</u>	<u>Amount</u>
Acute care	\$328,633,468
Administrative	<u>7,197,782</u>
Total	\$335,831,250

Year One (October 1, 1982 - September 30, 1983)

Enrollment:

89,683 **acute** care members (53,195 AFDC & AFDC\MAO, 28,322 SSI & SSI\MAO, 8,166 MN/MI) as of December 6, 1982. By December 12, 1983, enrollment had increased to 147,124 members (66,520 AFDC & AFDC\MAO, 29,506 SSI & SSI\MAO, and 51,098 MN/MI).

Program:

- AHCCCS began provision of Title XIX covered services but was waived from providing some mandatory services normally covered under traditional Medicaid. (SB 1001, Chapter 1, Laws of 1981).
- Legislation also contained language which enabled AHCCCS to create Healthcare Group (see Year 6).
- Coverage of human organ transplants included bone marrow, heart and kidney transplants for all Title XIX members under age 18.
- Services were also provided to State-only funded groups.
- AHCCCS paid fee-for-service for inpatient hospital costs based on 100% of covered billed charges.
- 18 Health Plans served AHCCCS members.

Waivers:

AHCCCS was waived from 14 provisions of the Social Security Act enabling the State to:

- exclude SNF services;
- exclude home health care;
- exclude nurse-midwife services;
- exclude family planning services;
- restrict freedom of choice of provider;
- exempt well baby care and services from co-payments;
- exclude eyeglasses, dental care and hearing as part of EPSDT services;
- obtain greater flexibility in arranging provider reimbursement agreements;
- exclude from Medicaid all incurred costs for eligible recipients prior to 10/1/82;
- impose cost sharing on mandatory services and individuals enrolled in an HMO;
- limit the scope of adult inpatient and outpatient mental health services to acute conditions;
- substitute an advisory panel of experts in place of the Medical Care Advisory Committee;
- be exempted from federal regulations requiring that State funding comprise at least 40 percent of the non-federal share of Medicaid expenses; and
- allow expenditures for certain items, which are not otherwise included as expenditures under Section 1903 of the Social Security Act, for example, 1) to guarantee six months eligibility in an AHCCCS Health Plan; and 2) to permit a one year lock and waive 75/25 member composition mix requirements.

Financial:

Source
TOTAL

SFY Expenditures
\$98,525,000

Total is estimated and includes funding from federal, state and other sources and was included in the DHS budget.

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- There were 46 ADHS FTEs staffing the AHCCCS program.
- In the spring of 1983, after Dr. Foley's departure as Director of AHCCCS, Donald Mathis served as Acting Director until J. Gregory Fahey was named the Director of AHCCCS on August 15, 1983.

Year Two (October 1, 1983 - September 30, 1984)

Enrollment:

185,409 **acute** care members (74,898 AFDC & AFDC/MAO, 30,582 SSI & SSI/MAO, and 79,929 MN/MI).

Program:

- The second Annual Medical Audit was conducted during July - September, 1984. Findings issued in November, 1984 concluded that AHCCCS providers render care similar to that received by private non-AHCCCS patients and that "...AHCCCS patients received the highest quality of medical care available..."
- AHCCCS began using a charge-based inpatient hospital cost reimbursement system, the Adjusted Billed Charges (ABC) system. This system was designed to hold reimbursement rates for hospital claims constant at 1984 levels, on a hospital-specific basis.
- On May 5, 1984 (HB 2551, Chapter 272, Laws of 1984) created an independent state agency, AHCCCS, and made the following other substantive changes:
 - Strengthened eligibility documentation requirements for MN/MI;
 - Based MN/MI eligibility determinations on an annualization of the previous 3 months' income rather than annualization of the prior month's income;
 - Allowed MN/MI to appeal directly to the State if their eligibility was denied, instead of to the county;
 - Permitted AHCCCS to defer the enrollment of hospitalized persons and pay for their care on a fee-for-service or adjusted billed charge basis;
 - Gave AHCCCS the authority to require the posting of performance bonds for AHCCCS contractors;
 - Directed AHCCCS to pay hospitals on an adjusted billed charge basis;
 - Authorized AHCCCS to pay hospitals directly for hospital care that was not paid in a timely manner by contracting Health Plans;
 - Permitted, in certain circumstances, written subcontract requirements to be waived;
 - Allowed AHCCCS to contract directly with hospital for discounted rates;
 - Required AHCCCS to establish a third party liability unit; and
 - Required AHCCCS to develop specific quality of care standards.
- 18 Health Plans served AHCCCS members.

Waivers:

- AHCCCS dropped two waivers. The agency began covering eyeglasses, dental care and hearing as part of EPSDT services and dropped the waiver that excluded from Title XIX all incurred costs for eligible recipients prior to 10/1/82 because it was no longer necessary.

Financial:	Source	SFY Expenditures	Percentage
	Federal	\$57,063,300	26.1
	State	81,270,100	37.2
	Other	<u>80,415,500</u>	<u>36.7</u>
	TOTAL	\$218,748,900	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- On March 16, 1984, after 18 months of administrative and budgetary problems, the contract with McAuto was terminated and the State took over the administration of AHCCCS.
- Donald F. Schaller, M.D. was appointed Director on April 12, 1984 by Governor Bruce Babbitt to replace J. Gregory Fahey, who remained as Deputy Director.
- On May 5, 1984, Governor Babbitt signed legislation making AHCCCS a separate state agency.
- Number of FTEs = 221

Year Three (October 1, 1984 - September 30, 1985)

Enrollment:

144,450 **acute** care members (71,948 AFDC & AFDC/MAO, 32,340 SSI & SSI/MAO, and 40,162 MN/MI).

Program:

- On May 10, 1985, the State Legislature passed a two-year extension of the AHCCCS program (SB 1226, Chapter 316, Laws of 1985). The bill also:
 - Added orthognathic surgery for children & podiatry as covered services effective October 1, 1985;
 - Modified reinsurance coverage to include certain outpatient services;
 - Clarified county residual responsibility for indigent care and county contributions for FY 86;
 - Required providers to submit claims within 9 months of date of service or face payment denial;
 - Required provider contract provisions to include maintaining deposits, bonds, financial reserves;
 - Provided immunity from civil liability or legal action for any person participating in review committee proceedings;
 - Clarified that third party payments which are collected and retained by the provider must be reflected in lower capitation rates paid to plans; and
 - Prohibited providers from billing members or referring unpaid accounts to collection or credit reporting agencies.
- 19 Health Plans served AHCCCS members.

Waivers:

- In July 1985, HCFA approved a two-year extension of the program to September 30, 1987.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$66,772,402	26.0
	State	124,620,647	48.6
	Other	<u>65,271,255</u>	<u>25.4</u>
	TOTAL	\$256,664,304	100.0

Does not include DSH payments and appropriations made to other State agencies

Administration:

- To strengthen administrative monitoring and control, the Fraud and Abuse and TPL Units were created.
- Number of FTEs = 307

Year Four (October 1, 1985 - September 30, 1986)

Enrollment:

151,146 **acute** care members (74,043 AFDC & AFDC/MAO, 34,869 SSI & SSI/MAO, and 42,234 MN/MI).

Program:

- Oral surgery for children under age 18, podiatry services, and total parenteral nutrition added as covered services effective October 1, 1985. (SB 1226, Chapter 316, Laws of 1985).
- Studies by the Arizona JLBC and SRI International in April 1986 showed AHCCCS to be more cost effective than comparable Medicaid systems.
- A Lou Harris study, commissioned by the Flinn Foundation and released in late 1985, reported that “from the patient’s perspective, the AHCCCS program seems to be working. It has improved access to health care for the people it serves and, by and large, they are pleased with the care they receive.
- 15 Health Plans served AHCCCS members

Waivers:

- No change in waivers.

Financial:	Source	SFY Expenditures	Percentage
	Federal	\$70,120,100	26.7
	State	141,553,500	53.9
	Other	<u>50,981,400</u>	<u>19.4</u>
	TOTAL	\$262,655,000	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- Rule modifications initiated by AHCCCS resulted in the refinement of eligibility requirements and strengthened third party recovery activity.
- Number of FTEs = 325

Year Five (October 1, 1986 - September 30, 1987)

Enrollment: 192,305 **acute** care members (88,059 AFDC & AFDC/MAO, 36,949 SSI & SSI/MAO, 47,003 MN/MI, 19,161 EAC and 1,133 ELIC).

Program:

- Effective January 1987, State legislation (HB 2086, Chapter 380, Laws of 1986) created the Children's Care Program which created two new eligibility groups:
 - Eligible Assistance Children (EAC) - A State-funded group of children whose household receives food stamps: and
 - Eligible Low Income Children (ELIC) - A category of children in families not receiving food stamps with income exceeding the state MN/MI level but not the federal poverty level.
- The February 1987 SRI Report covering the April 1984 - September 1985 period found that "...overall, AHCCCS made substantial progress in stabilizing the administration of the program during the second 18 months" of AHCCCS operation.
- On May 21, 1987 Governor Evan Mecham signed Senate Bill 1418 placing the AHCCCS program permanently in statute. The Bill also authorized the development of a Title XIX long-term care program.
- Effective August 17, 1987, medically necessary kidney, cornea, and bone transplants, and immunosuppressant medications for these transplants became covered services for all members. (SB 1418, Chapter 332, Laws of 1987)

14 Health Plans serve AHCCCS members.

Waivers:

- The June 18, 1987 Waiver Request incorporated a long-term care program request.
- On September 29, 1987, HCFA granted a one-year extension to September 30, 1988.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$87,147,800	30.4
	State	127,822,300	44.5
	Other	<u>72,201,600</u>	<u>25.1</u>
	TOTAL	\$287,171,700	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- Leonard J. Kirschner, M.D., M.P.H. appointed Director on February 2, 1987 by Governor Mecham.
- Number of FTEs = 350

Year Six (October 1, 1987 - September 30, 1988)

Enrollment: 216,425 **acute** care members (100,014 AFDC & AFDC/MAO, 38,760 SSI & SSI/MAO, 47,680 MN/MI, 22,613 EAC, 1,525 ELIC, 4,139 SOBRA Children and 1,694 SOBRA Women). 384 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Nurse-midwife services added effective October 1, 1987.
- Effective January 1, 1988 implemented the SOBRA program for pregnant women and children under 5 years of age with income up to 100% FPL. (SB 1418, Chapter 332, Laws 1987)
- Heart transplants and immunosuppressant medications added for categorically eligible AHCCCS members effective April 12, 1988.
- Adopted a guaranteed enrollment period for pregnant women. (SB 1418, Chapter 332, Laws 1987)
- In cooperation with IHS, AHCCCS developed a pilot project to ensure that all AHCCCS-eligible American Indian children residing on-reservations were provided with EPSDT services.
- The SRI International survey of member's access to medical care and satisfaction found that fewer than 1 in 22 AHCCCS members reported difficulties in receiving care, only half of the rate of the New Mexico control group. In addition, 78 percent of AHCCCS members stated they were satisfied with the care they received.
- 13 Health Plans served AHCCCS members.

Healthcare Group

- Effective January 1, 1988, small companies with up to 25 employees were able to purchase health insurance in Pima, Gila, Maricopa, and Pinal counties through Healthcare Group and receive care through AHCCCS Health Plans. (SB 1001, Chapter 1, Laws of 1981)

Waivers:

- Added a waiver that enabled the State to provide complete acute care Medicaid coverage to pregnant women during the 60-day period after the end of pregnancy and for the new optional categorically needy group of SOBRA pregnant women with incomes up to the FPL.

Financial:	Source	SFY Expenditures	Percentage
	Federal	\$111,982,900	29.7
	State	187,193,300	49.6
	Other	<u>78,049,500</u>	<u>20.7</u>
	TOTAL	\$377,225,700	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

Number of FTEs = 464

Year Seven (October 1, 1988 - September 30, 1989)

Enrollment: 270,642 **acute** care members (125,708 AFDC & AFDC/MAO, 36,803 SSI & SSI/MAO, 39,690 MN/MI, 30,537 EAC, 3,236, ELIC, 23,031, 28,130 SOBRA Children, and 6,538 SOBRA Women), 10,616 **ALTCS** members. 852 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Effective October 1, 1988, eligibility age limits for children whose families were receiving food stamps became automatically eligible for AHCCCS were raised from 6 to under 14. (SB 1418, Chap 332, 1987)
- Effective October 1, 1988, eligibility age limits for SOBRA children with incomes to 100% FPL raised from under 5 years of age to under 6 years of age. (SB 1182, Chapter 3, Laws of 1988)
- Liver transplants for categorical children under age 18 added effective October 1, 1988. (SB 1486, Chapter 302, Laws of 1988)
- Family planning services, but not abortion or abortion counseling, added October 1, 1988. (SB 1486, Chapter 302, Laws of 1988)
- Home health care added January 1, 1989. (SB 1418, Chapter 332, Laws of 1987)
- Qualified Medicare Beneficiaries (QMB) added effective July 1, 1989. (SB 1151, Chapter 5, Laws of 1989)
- In late June, 1989, the legislature approved emergency legislation requiring counties, effective July 1, 1989, to process AHCCCS applicants first under federally funded categories before processing them under State-only funded categories.
- The five year January 1989 SRI International study found that AHCCCS was less expensive, provided higher quality of care for children and had better access than traditional Medicaid.
- 13 Health Plans served AHCCCS members.

ALTCS

- ALTCS program (SB 1418, Chapter 332, Laws of 1987) began in two phases: 1) DD population added December 19, 1988; and 2) EPD population added January 1, 1989.
- 5 Program Contractors served ALTCS members.

Healthcare Group

- Services are limited to Pima county effective February 1, 1989.

Waivers:

- Dropped three waivers that: excluded SNF services, nurse-midwife services, and family planning services.
- Added four waivers that enabled the State to:
 - provide HCBS to individuals with incomes not exceeding 300% SSI;
 - be exempt from federal requirements for timely financial eligibility determination for long term care recipients during the start up of ALTCS;
 - exclude hospitalized and others not requiring long term care services from the optional institutionalized eligibility categories; and
 - perform inspection of care on a sample basis.
- The 1115 waiver was extended on November 23, 1988 for 5 years until September 30, 1993.

Financial:

<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
Federal	\$192,720,200	36.1
State	244,260,300	45.9
Other	<u>95,724,800</u>	<u>18.0</u>
TOTAL	\$532,705,300	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

Number of FTEs = 834

Year Eight (October 1, 1989 - September 30, 1990)

Enrollment: 319,324 **acute** care members (150,693 AFDC & AFDC/MAO, 39,538 SSI & SSI/MAO, 40,172 MN/MI, 25,934 EAC, 3,187 ELIC, 50,782 SOBRA Children, and 9,018 SOBRA Women), 13,102 ALTCS members. 2,072 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Autologous bone marrow transplants added October 1, 1989 for Title XIX members. (SB 1348, Chapter 293, Laws of 1989)
- Legislation directed AHCCCS to continue re-evaluating its existing hospital reimbursement system. (SB 1348, Chapter 293, Laws of 1989)
- SOBRA pregnant women, children and infants income limits increased from 100% FPL to 133% FPL effective April 1, 1990. SOBRA was initially raised (SB 1348, Chapter 293, Laws of 1989) to 130% FPL to become effective July 1, 1990, however, federal law raised SOBRA to 133% FPL in the interim, making it necessary to pass State legislation to comply with federal law effective April 1, 1990. (HB 2249, Chapter 27, Laws of 1989)
- Legislation created an Advisory Council on Indian Health Care. (SB 1348, Chapter 293, Laws of 1989)
- 13 Health Plans served AHCCCS members.

ALTCS

- Congress repealed most elements of the Medicare Catastrophic Coverage Act of 1988. Some elements which affected Medicaid remained in place.
- HCFA set HCBS cap at 15% of the EPD population.
- 5 Program Contractors served ALTCS members.

Healthcare Group

- Services expanded to Cochise County in January 1990 and Maricopa County in April 1990.

Waivers:

- On February 6, 1990, added a waiver enabling the State to phase in OBRA 89 requirements related to treatment of mental health service needs in the EPSDT program.

Financial:

<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
Federal	\$357,087,200	47.7
State	267,219,900	35.7
Other	<u>123,826,500</u>	<u>16.6</u>
TOTAL	\$748,133,600	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- AHCCCS terminates the contract with Deloitte and Touche, a private firm that had been hired to develop the Prepaid Medical Management Information System (PMMIS).
- The federal government started paying "real time" FFP for acute care Health Plan capitation payments.
- Number of FTEs = 888

Year Nine (October 1, 1990 - September 30, 1991)

Enrollment: 383,824 **acute** care members (191,951 AFDC & AFDC/MAO, 44,933 SSI & SSI/MAO, 43,248 MN/MI, 23,129 EAC, 4,023 ELIC, 66,511 SOBRA Children, and 10,029 SOBRA Women), 14,501 **ALTCS** members. 3,817 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Expansion of SOBRA eligibility from 133% FPL to 140% FPL for pregnant women and infants effective October 1, 1990. (HB 2351, Chapter 333, Laws of 1990)
- QMB eligibility increased to individuals with incomes up to 100% FPL effective January 1, 1991. (SB 1140, Chapter 213, Laws of 1991)
- OBRA 90 mandates adopted: infants retain eligibility for 12 months if mother would be eligible if still pregnant; and, children born on or after September 30, 1983 with incomes up to 100% FPL eligible up to age 18 effective July 1, 1991. (SB 1140, Chapter 213, Laws of 1991)
- 15 Health Plans served AHCCCS members.

ALTCS

- HCFA set HCBS cap at 18 percent of the total budget for the EPD population.
- A 1991 Laguna Research study showed that long term care costs under AHCCCS were lower than in states with case management services, and that the preadmission screening was better than in many other states.
- 7 Program Contractors served ALTCS members.

Behavioral Health

- AHCCCS functions in a regulatory role for ADHS which is responsible, by statute, for the provision of behavioral health services to Title XIX eligible persons.
- Phased in behavioral health services (HB 2554, Chapter 334, Laws of 1990) in the acute care program for Title XIX members: 1) under the age of 18 who are SED, effective October 1, 1990; and 2) under age 18 who are not SED, effective on April 1, 1991.

Indian Health Care

Under terms of a settlement between AHCCCS and IHS: 1) AHCCCS agreed to pay before IHS for services provided to AHCCCS eligible Native Americans who are referred off-reservation for health care services; 2) the Federal government agreed to pay \$2 million for health care services already rendered; and 3) both parties agreed to work towards an improved eligibility process on Arizona's reservations.

Healthcare Group

- Effective August 1991, the limitation on the number of employees in a company is expanded from 25 to 40 employees. (HB 2077, Chapter 299, Laws of 1991)

Waivers:

- Dropped the waiver that exempted the State from federal requirements for timely financial eligibility determination for long term care recipients during the start up of ALTCS.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$467,687,600	48.6
	State	333,186,800	34.6
	Other	161,248,200	16.8
	TOTAL	\$962,122,600	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- Number of FTEs = 923
- In early March 1991, after an extensive test period, PMMIS becomes operational.

Year Ten (October 1, 1991 - September 30, 1992)

Enrollment: 431,633 **acute** care members (213,592 AFDC & AFDC/MAO, 51,343 SSI & SSI/MAO, 48,553 MN/MI, 21,840 EAC, 4,942 ELIC, 80,663 SOBRA Children, and 10,700 SOBRA Women), 16,688 ALTCS members. 6,190 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Optional income Medicaid children (section 1902(r)(2) of the Social Security Act) up to age 14 added July 1, 1992. (No bill)
- 14 Health Plans served AHCCCS members.

ALTCS

- A Second Implementation and Operation Report, completed by Laguna Research Associates and released in April 1992, concluded that the ALTCS program demonstrated its ability to set up a network of prepaid, capitated Program Contractors and offered the potential for cost savings.
- HCBS cap set at 25% of the EPD population.
- 7 Program Contractors served ALTCS members

Behavioral Health

- Behavioral health services are expanded to Title XIX SMI and non-SMI members age 18 through 20, effective October 1, 1991. The BH services delivered to this group are provided through the Health Plans. (SB 1502, Chapter 301, Laws of 1992).

Healthcare Group

- Services expanded to Coconino county in April 1992.

Waivers:

- Dropped six waivers that enabled the State to:
 - phase in OBRA 89 requirements related to treatment of EPSDT mental health service needs;
 - exclude home health;
 - provide complete acute care Medicaid coverage to pregnant women during the 60-day period after the end of pregnancy and for the new optional categorically needy group of pregnant women;
 - exempt well baby care and services from co-payments (moved to co-payment waiver);
 - substitute an advisory panel of experts for the Medical Care Advisory Committee; and
 - be exempted from federal regulations requiring that State funding comprise at least 40 percent of the non-federal share of Medicaid expenses.
- 1115 waiver extended until October 1, 1994.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$646,687,000	53.2
	State	420,450,500	34.6
	Other	149,020,200	12.3
	TOTAL	\$1,216,157,700	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- AHCCCS finished as first runner-up from a field of 132 entrants nationwide for the American Healthcare Systems Award given to the most innovative program serving the medically indigent.
- The federal government certifies the PMMIS.
- The Office of the General Counsel is created as a result of Governor Symington's Project SLIM.
- Mabel Chen is named AZ Administrator of the Year by the AZ Administrators Association.
- Number of FTEs = 932

Year Eleven (October 1, 1992 - September 30, 1993)

Enrollment: 451,914 **acute** care members (223,622 AFDC & AFDC/MAO, 57,362 SSI & SSI/MAO, 41,912 MN/MI, 3,406 EAC, 3,430 ELIC, 15,590 CMP, 93,572 SOBRA Children, 11,417 SOBRA Women, 171 State Emergency Services, and 1,432 Federal Emergency Services), 17,886 **ALTCS** members. 9,150 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- On March 1, 1993, AHCCCS began a prospective inpatient hospital reimbursement system based on levels of care (tiers) and a hospital-specific cost to charge ratio for covered outpatient care.
- Definition of primary care practitioner expanded to include nurse practitioners and physician assistants.
- Effective April 1, 1993, (and retro to 10/16/90) allogeneic bone marrow transplants covered for Title XIX members. (HB 2508, Chapter 302, Laws of 1992)
- Effective July 1, 1993, persons eligible for state funded only group have to prove citizenship or legal alien status. Undocumented aliens only eligible for emergency services. (HB 2007, Chapter 6, Laws of 1993)
- Effective July 1, 1993, doctor/home visit co-payments increased from \$1 to \$5 for state-only program.
- 15 Health Plans serve AHCCCS members.

ALTCS

- In April 1993, Laguna Research Associates released an Outcome Report that evaluated acute care and long term care costs, utilization and nursing home quality of care. The report found that acute care costs continued to show savings and that ALTCS costs were less than traditional Medicaid.
- HCBS cap set at 30% of the EPD population.
- 8 Program Contractors served ALTCS members.

Behavioral Health

- Phased in behavioral health services to: 1) Title XIX seriously mentally ill members age 21 and older enrolled in acute care effective November 1, 1992; and, 2) Title XIX members age 65 and older enrolled in ALTCS effective July 1, 1993.

Healthcare Group

- Services expanded to the remaining 11 Arizona counties effective March 1, 1993.

Waivers:

- Dropped the waiver that enabled the State to perform inspection of care on a sample basis.
- Added two waivers that enabled the State to: 1) provide attendant care services on a non-statewide basis for the DD population; and, 2) receive payment for outpatient drugs without complying with the requirements of OBRA 90 pertaining to drug rebate and drug use review.
- On January 6, 1993, the 1115 waiver was extended for a year until September 30, 1994.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$815,014,000	56.4
	State	470,352,600	32.5
	Other	160,689,600	11.1
	TOTAL	\$1,446,056,200	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- Mabel Chen, M.D. appointed as Acting Director on August 1, 1993.
- As a result of Governor Symington's Project SLIM, AHCCCS began outsourcing warehouse, mailroom and copying services in February 1993 and third party liability recoveries in March 1993.
- Number of FTEs = 963

Year Twelve (October 1, 1993 - September 30, 1994)

Enrollment: 443,665 **acute** care members (221,528 AFDC & AFDC/MAO, 62,660 SSI & SSI/MAO, 30,077 MN/MI, 2,182 EAC/ELIC, 13,028 CMP, 99,050 SOBRA Children, 11,290 SOBRA Women, 233 State Emergency Service, and 3,617 Federal Emergency Service), 19,449 **ALTCS** members. 15,535 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Use of HCFA Common Procedure Coding System mandated effective October 1, 1993.
- The annual AHCCCS Open Enrollment period held from August 8-31, 1994 coincided with the acute care bid process, which elicited more response and interest than any other year. 61,727 open enrollment choices were made and an additional 106,379 AHCCCS members were reassigned to a Health Plan that was available in their service area because their previous plan was not given a contract. In anticipation of this response, AHCCCS instituted the Automated Phone Log and added an additional 11 temporary enrollment sites. This process reduced the traditionally high level of staff stress and improved customer service.
- A record number of bids submitted by county (95) during the RFP process. 42 acute care contracts awarded for the year beginning October 1, 1994. All rural counties have at least two Health Plans.
- 15 Health Plans served AHCCCS members.

ALTCS

- ALTCS contracts, which incorporated program changes, new monitoring requirements and other information, are renewed for all eight ALTCS Program Contractors.
- In addition to Maricopa and Pima, two new counties were awarded ALTCS contracts, Yavapai and Cochise.
- HCBS cap set at 35% of the EPD population.
- 8 Program Contractors served ALTCS members.

Waivers:

- On August 17, 1994, the 1115 waiver was extended for an additional three years until September 30, 1997.
- No change in current waivers.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$934,712,500	59.4
	State	463,805,800	29.4
	Other	176,404,200	11.2
	TOTAL	\$1,574,922,500	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- Mabel Chen, M.D. appointed Director on October 19, 1993 by Governor Fife Symington.
- The AHCCCS Quality Initiative, a total quality management program, is implemented.
- Number of FTEs = 1,015

Year Thirteen (October 1, 1994 - September 30, 1995)

Enrollment: 439,162 **acute** care members (208,698 AFDC & AFDC/MAO, 66,714 SSI & SSI/MAO, 29,215 MN/MI, 1,988 EAC/ELIC, 8,376 CMP, 99,224 SOBRA Children, 12,161, SOBRA Women, 3,479 Family Planning Services, 307 State Emergency Service, 4,180 Federal Emergency Service, 4,820 QMB only), 20,919 **ALTCS** members. 18,781 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- Baby Arizona, a prenatal care program began in Pima (Nov. 1994) and Maricopa (May 1995) counties.
- Members allowed to self-refer for dental services.
- Effective March 22, 1995, added heart, liver and bone marrow transplants for non-Title XIX members and liver transplants for adult Title XIX members. (SB 1253, Chapter 16, Laws of 1995)
- Effective June 1, 1995, Advantage Health and Health Choice merge into Health Choice of Arizona.
- On August 1, 1995, the Family Planning Services Extension Program was implemented. This program allows women to continue receiving only family planning services for up to 24 months after losing SOBRA eligibility. Services are covered by AHCCCS on a FFS basis.
- 14 Health Plans served AHCCCS members.

ALTCS

- Developed a new age-specific PAS for the DD population.
- On September 1, 1995, adopted a functional level PAS for ALTCS members who fail the at-risk of institutionalization test at redetermination. Persons who pass the new PAS could continue in the program and receive HCBS. (SB 1325, Chapter 322, Laws of 1994)
- HCBS cap set at 40% of the EPD population.
- 8 Program Contractors served ALTCS members.

Behavioral Health

- A risk-based RFP for the provision of Title XIX covered mental health services for eligible children and seriously mentally ill adults was developed during October and awarded to ADHS in December 1994.

Waivers:

- Added waivers to:
 - * streamline and simplify acute and ALTCS eligibility requirements.
 - * adopt a functional PAS for persons enrolled in ALTCS and who subsequently fail the at-risk of institutionalization test at time of redetermination.
 - * permits SOBRA newborns to remain Medicaid eligible for the first 12 months after birth without consideration of the mother's continued Medicaid eligibility
 - * extend family planning services for women who lose Title XIX SOBRA eligibility.
 - * provide supported employment services to DD clients eligible for ALTCS transitional.
- AHCCCS is seeking approval of waivers which would:
 - * permit Medicare/Medicaid dual eligibles four options to for receiving Medicare/Medicaid services.
 - * permit AHCCCS, with IHS, to operate a managed care pilot program on-reservation.

Financial:	<u>Source</u>	<u>SFY Expenditures</u>	<u>Percentage</u>
	Federal	\$1,088,906,000	60.3
	State	\$529,650,000	29.3
	Other	<u>\$187,959,000</u>	<u>10.4</u>
	TOTAL	\$1,806,515,000	100.0

Does not include DSH payments and appropriations made to other State agencies.

Administration:

- In October 1994, two AHCCCS' Quality Initiative teams won the Governor's Award of Excellence.
- On December 6, 1994, the Council of State Governments awarded AHCCCS an Innovation Award.
- Richard Potter, OMC Assistant Director, named Administrator of the Year in June.
- Number of FTEs = 1,061

Year Fourteen (October 1, 1995 - September 30, 1996)

Enrollment: 455,573 **acute** care members (206,478 AFDC & AFDC/MAO, 69,590 SSI & SSI/MAO, 28,529 MN/MI, 2,369 EAC/ELIC, 4,206 CMP, 106,129 SOBRA Children, 11,914 SOBRA Women, 15,358 Family Planning Services, 317 State Emergency Service, 5,335 Federal Emergency Service, and 5,348 QMB Only), 22,350 **ALTCS** members. 20,377 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- In October 1995, a GAO study showed: AHCCCS produced noteworthy cost savings; competitive bidding is an effective tool, and, access to care for AHCCCS members remains high.
- A February 1996 Laguna Research report stated that cumulative cost savings for the AHCCCS program are almost \$500 million through FY93 compared to a traditional Medicaid program.
- Effective July 1, 1996, MN/MI eligibility is denied for Medicare eligible applicants and members who reside in a county where a Medicare HMO operates. An estimated 500 individuals will be affected.
- On September 23, 1996, HCFA presented the Baby Arizona Project with the HCFA Beneficiary Services Certificate of Merit for implementing a successful public/private partnership to encourage low-income pregnant women to receive early and continuous prenatal care.
- 14 Health Plans serve AHCCCS members.

ALTCS

- 8 Program Contractors serve ALTCS members.
- On October 1, 1995, the Adult Care Home Pilot program began permitting a limited number of EPD individuals to receive HCBS in an adult home setting.
- Supportive Residential Living Centers added as a permanent setting effective July 20, 1996.

Behavioral Health

- Effective October 1, 1995, behavioral health services added for Title XIX non-SMI adults age 21 and older enrolled in the acute care program and adults age 21-64 enrolled in ALTCS, resulting in services to all Title XIX members. (SB 1215, Chapter 204, Laws of 1995)

Healthcare Group

- In June, Healthcare Group recognized as a semifinalist in the 1996 Innovations in American Government Awards sponsored by the Ford Foundation and the JFK School of Government at Harvard University.

Waivers:

- Dropped the waiver that allowed AHCCCS to limit adult mental health services to acute conditions only.
- Withdrew Medicare/Medicaid dual eligibles waiver request on March 22, 1996.

Financial	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
Expenditures: This is the first year using FFY expenditures	Federal	\$1,239,500,800	65
	State	489,042,800	25
	Other	197,398,800	10
	TOTAL	\$1,925,942,400	100

Includes DSH payments and appropriations made to other State agencies.

Administration:

- John H. Kelly appointed as Acting Director on March 25, 1996.
- Richard Potter named Deputy Director in September 1996.
- Gloria Collins, DMS Manager, named AZ Administrator of the Year by the AZ Administrator's Association.
- Major redesign of FFS claims system operational on April 15, 1996.
- Number of FTEs = 1,091

Year Fifteen (October 1, 1996 - September 30, 1997)

Enrollment: 410,854 **acute** care members (176,579 TANF & TANF/MAO, 61,715 SSI & SSI/MAO, 21,126 MN/MI, 1,954 EAC/ELIC, 41 CMP, 106,763 SOBRA Children, 31,093 SOBRA Women, 1,576 Family Planning Services, 216 State Emergency Service, 4,170 Federal Emergency Service, and 5,621 QMB Only), 24,109 **ALTCS** members. 21,147 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- 13 Health Plans served AHCCCS members. During the year, three Health Plans were terminated:
 - * Arizona Health Concept effective November 30 in Maricopa county. .
 - * Regional AHCCCS Health Plan effective April 30 in Pinal County.
 - * Intergroup Select Health Plan effective May 31 in Maricopa County.
- The *AHCCCS Member Survey Report* was published. This report summarizes the results of a telephone survey of over 14, 000 acute care members conducted in 1996.
- Effective September 1, applicants at DES may pre-select their Health Plan. Once categorical eligibility is determined, if no plan is selected, the member is auto-assigned to a Health Plan (eliminates 3 day FFS window). Auto-assigned members are notified that they have 10 days to request a plan change.
- Pursuant to federal Welfare Reform legislation, Arizona enacted eligibility legislation for qualified persons and undocumented persons.

ALTCS

- 8 Program Contractors Health Plans served ALTCS members.
- Effective July 21, instead of an annual PASARR, ALTCS members residing in a NF who have mental illness or mental retardation will be reviewed when the NF reports a significant change in physical/mental condition.

Behavior Health

- In July, ADHS took over temporary operation of ComCare, the Maricopa County RBHA because a behavioral health emergency was declared by the Governor.

Waivers:

- In September, received informal HCFA approval on waiver request to extend AHCCCS through 9/30/98.
- Acting on a 1996 initiative passed by voters, submitted a request to HCFA in May to extend acute care Title XIX eligibility to low income adults & children with income up to 100% of the federal poverty level (FPL) and to implement a Medical Expense Deduction program for persons with unpaid medical bills. Responded to detailed HCFA questions on proposal in August.

Financial	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
Expenditures:	Federal	\$1,220,058,700	60
	State	576,193,700	29
	Other	<u>225,980,100</u>	<u>11</u>
	TOTAL	\$2,022,232,500	100

Includes DSH payments and appropriations made to other State agencies.

Administration:

- In March 1997, John Kelly is appointed AHCCCS Director.
- Number of FTEs = 1,111

Year Sixteen (October 1, 1997 - September 30, 1998)

Enrollment: 406,376 **acute** care members (142,316 TANF Related MAO, 72,901 SSI & SSI/MAO, 21,365 MN/MI, 1,406 EAC/ELIC, CMP, 120,228 SOBRA Children, 12,591 SOBRA Women, 24,528 Family Planning Services, 229 State Emergency Service, 4,668 Federal Emergency Service, and 6,144 QMB Only), 25,511 **ALTCS** members. 14,874 members enrolled in **Healthcare Group**.

Program:

Acute Care

- Five-year contracts awarded to twelve Health Plans in nine geographic services areas (GSAs). Two Health Plans, Family Health Plan of NEAZ and Pima Health Plan, received capped contracts. On August 1, the Family Health Plan cap was lifted.
- Effective October 1, Health Plans have responsibility for :
 - * members in the 24-month extended Family Planning Services Extension Program;
 - * claims incurred during Prior Period (time between eligibility effective date and enrollment date);
 - * compliance with a revised EPSDT Periodicity Schedule (28 visits recommended from 0-20 years)
- Effective January 1998, provide 48-hour stay for normal maternity delivery, 96 hours for cesarean delivery.
- During its fourth year, Baby Arizona becomes available in every county. The percentage of AHCCCS eligible women starting care in the first trimester of their pregnancies increased about 2.5 percent per year in 1996 and 1997, compared to .5% per year from 1992 to 1995.
- Scanable Member ID cards are issued to all AHCCCS members beginning in October 1998.
- KidsCare, Arizona's Title XXI Children's Health Insurance Program, is implemented on November 1.
- Annual enrollment, previously provided for all members during a period in August, changed to an annual enrollment based on the member's enrollment anniversary date.

ALTCS

- HCBS cap is set at 45% of EPD population.
- Adult Care Homes become a permanent alternative setting for ALTCS members under a new category of licensure known as "assisting living facilities".

Behavioral Health

- In September, following a year of ADHS operation of ComCare which resulted from a behavioral health emergency, Value Options is awarded the contract for the Maricopa county RBHA.

Healthcare Group

- In February, Healthcare Group implemented the Premium Sharing Pilot program in four counties for three years. The program provides health care for low-income persons for a sliding scale monthly premium.

Waivers:

- Current waiver expires 9/30/98. A one-year waiver extension was submitted on August 13, 1998. The 100% FPL Waiver, which was submitted in May 1997 and is pending approval, includes a 5 year extension of the 1115 Demonstration and Research Waiver.

Financial	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
Expenditures:	Federal	\$1,271,307,200	60%
	State	618,016,800	28%
	Other	239,775,600	12%
	TOTAL	\$2,129,099,600	100%

Includes DSH payments and appropriations made to other State agencies.

Administration: Number of FTEs =1,159

Year Seventeen (October 1, 1998 - September 30, 1999)

Enrollment: 446,242 **acute** care members (133,837 TANF Related MAO, 73,690 SSI & SSI/MAO, 20,248 MN/MI, 372 EAC/ELIC, 21,256 KidsCare, 148,757 SOBRA Children, 13,021 SOBRA Women, 21,903 Family Planning Services, 237 State Emergency Service, 5,956 Federal Emergency Service, and 6,965 QMB Only), 25,511 **ALTCS** members. 11,474 members enrolled in **Healthcare Group**.

Program:

Acute Care

- AHCCCS begins preparations for a targeted pilot program on October 1, 1999 using a universal application.
- The Baby Arizona Project completed its 5th year of operation on June 30, 1999. The program, which promotes early access to prenatal care and streamlines eligibility for Medicaid coverage for pregnant women, helped more than 6,200 expectant mothers enroll in AHCCCS Health Plans during Year Seventeen.

ALTCS

- In November 1998, an ALTCS –related workshop is attended by over 300 persons. Over 95% of the attendees were satisfied with the conference and with the information they received.

Behavioral Health

- Several independent studies of the five Regional Behavioral Health Authorities are conducted to assess children's behavioral health services in Arizona.

KidsCare

- On November 1, 1998, AHCCCS implemented KidsCare, Arizona's Children's Health Insurance Program (CHIP) which received approval from HCFA on September 18, 1998.

Waivers:

Waiver extension expired 9/30/99. New AHCCCS 3-year waiver began October 1, 1999.

Financial Expenditures (Title XIX)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	1,385,405,391	61%
	State	637,112,823	28%
	Other	<u>244,392,735</u>	<u>11%</u>
	TOTAL	\$ 2,266,910,949	100%

Includes DSH payments and appropriations made to other State agencies.

Financial Expenditures (Title XXI)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	9,235,784	58%
	State	<u>6,731,511</u>	<u>42%</u>
	TOTAL	\$ 15,967,295	100%

Administration:

- Phyllis Biedess becomes AHCCCS Director in April 1999.
- Branch McNeal becomes AHCCCS Deputy Director in August 1999.
- Number of FTEs = 1,262

Year Eighteen (October 1, 1999 - September 30, 2000)

Enrollment: 509,054 **acute** care members (180,951 TANF & TANF/MAO, 75,220 SSI & SSI/MAO, 17,194 MN/MI, 489 EAC/ELIC, 28,073 KidsCare, 148,320 SOBRA Children, 11,604 SOBRA Women, 21,138 Family Planning Services, 225 State Emergency Service, 8,067 Federal Emergency Service, and 7,773 QMB Only), 30,003 **ALTCS** members. 11,667 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- An April 2000 survey conducted by the Behavior Research Center of 734 households shows that 70 percent of households have some degree of familiarity with AHCCCS, a much higher rate than anticipated.
- A fall 1999 survey of 291 dentists who serve AHCCCS members showed that 70% of the providers said they had seen major improvements in the previous 12-24 months in the way services were delivered. During that period, most Health Plans switched from capitated agreements to fee-for-service payments. Providers felt this resulted in "more reasonable" compensation.

ALTCS

- For the first time since the inception of the ALTCS/EPD program in January 1989, members in Maricopa county will be provided with a choice of Program Contractors effective October 1, 2000. On June 1, 2000, AHCCCS awarded contracts totaling \$290 million annually to 3 Arizona health care companies: Maricopa Long Term Care Plan, Lifemark Health Plans, and Mercy Care Plan.
- In April 2000, HCFA removed the ALTCS program's HCBS cap retroactively to October 1, 1999. The cap had been in place since the beginning of the ALTCS program and had been steadily increased. Removal of the cap permits the agency to respond to growth in services such as Alternative Residential Living Facilities, an increasingly popular option for individuals.
- The 17th Annual Home and Community Based Services (HCBS) conference was hosted from October 31 through November 2, 1999 and 100% of attendees classified the conference "a valuable experience".

Behavioral Health

- The Psychotropic Medication Initiative began on October 1, 1999 to provide funding to Health Plans to allow Primary Care Providers (PCPs) to prescribe psychotropic medication to members with diagnoses of mild depression, anxiety and Attention-Deficit Hyperactivity disorders.

Waivers:

- HCFA approved a 3-year waiver extension for the period from October 1, 1999 through September 30, 2002 on July 5, 2000.

Financial Expenditures (Title XIX)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	1,507,442,406	62%
	State	690,260,622	28%
	Other	<u>253,048,290</u>	<u>10%</u>
	TOTAL	\$ 2,450,751,318	100%

Includes DSH payments and appropriations made to other State agencies.

Financial Expenditures (Title XXI)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	34,696,421	72%
	State	<u>13,517,417</u>	<u>28%</u>
	TOTAL	\$ 48,213,838	100%

Administration:

- The agency experienced no significant Y2K related problems as a result of extensive planning, preparation, and testing.
- Number of FTEs = 1,269

Year Nineteen (October 1, 2000 - September 30, 2001)

Enrollment: 624,770 **acute** care members (338,977 TANF & TANF/MAO, 88,925 SSI & SSI/MAO, 28,184 MN/MI, 1 EAC, 53,685 KidsCare, 79,515 SOBRA Children, 8,560 SOBRA Women, 16,607 Family Planning Services, 217 State Emergency Service, 9,146 Federal Emergency Service, and 953 QMB Only), 32,720 **ALTCS** members. 10,706 persons enrolled in **Healthcare Group**.

Program:

Acute Care

- In November, Arizona voters approved Proposition 204, the Healthy Arizona Initiative, which expanded eligibility under AHCCCS to 100% of the federal poverty level (FPL). In January 2001, the Centers for Medicare and Medicaid Services (CMS) approved AHCCCS' waiver request to expand eligibility to 100% of the FPL and eliminate prior quarter coverage to new enrollees in both the acute care and ALTCS program.
- In the spring of 2001, AHCCCS initiated Medicaid in the Public Schools (MIPS) to reimburse school districts for services provided to Medicaid-eligible students in special education classes. AHCCCS contracted with Arizona Physicians IPA to handle the school districts claims. Public schools, charter schools not associated with a school district and the Arizona School for the Deaf and Blind are eligible.

ALTCS

- The National Health Care Purchasing Institute honored AHCCCS with the National Health Care Purchasers Award for Public Sector Purchasers for awarding three contracts for long term care in Maricopa County. Prior to these contracts, only Maricopa Long Term Care Plan had a contract to deliver services to the more than 10,000 elderly or physically disabled ALTCS members in the county.

Behavioral Health

- In June 2001, Judge Roll of the United States District Court, District of Arizona granted final approval to the proposed JK settlement agreement (No. CIV 91-261 TUCJMR). The term of the agreement is until 2007. The obligations of AHCCCS under this settlement agreement center on the delivery of services to children and families according to a set of principles aimed at providing timely, accessible, culturally appropriate services which are designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults.

Waivers:

- On January 18, 2001, CMS approved AHCCCS' request to expand eligibility to 100% of the FPL for the acute care program and waive the requirement to provide prior quarter coverage to new enrollees in both the acute care and ALTCS program.

Financial Expenditures (Title XIX)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	1,804,030,465	64%
	State	742,042,550	26%
	Other	<u>282,830,544</u>	<u>10%</u>
	TOTAL	\$ 2,828,903,559	100%

Includes DSH payments and appropriations made to other State agencies.

Financial Expenditures (Title XXI)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	56,505,943	75%
	State	<u>18,449,444</u>	<u>25%</u>
	TOTAL	\$ 74,955,387	100%

Administration:

- Number of FTEs = 1,330
- In May 2001, The National Health Care Purchasing Institute honored AHCCCS with the National Health Care Purchasers Award for Public Sector Purchasers for awarding three contracts for long term care in Maricopa County.

Year Twenty (October 1, 2001 - September 30, 2002)

Enrollment: 791,655 **acute** care members (447,314 TANF & TANF/MAO, 95,277 SSI & SSI/MAO, 86,447 AHCCCS Care, 3,825 MED, 47,542 KidsCare, 74,425 SOBRA Children, 8,801 SOBRA Women, 8,794 Family Planning Services, 16 Breast and Cervical Cancer, 2,042 State Emergency Service, 15,936 Federal Emergency Service, and 1,236 QMB Only), 35,645 **ALTCS** members. 13,147 persons enrolled in **Healthcare Group**.

Program:

- In October 2001, AHCCCS implemented a Universal Application to simplify the eligibility process for individuals and families. Users of the Universal Application include the general public, eligibility staff, hospitals, advocacy groups, community-based organizations and other agencies.

Acute Care

- On January 1, 2002, AHCCCS began coverage of breast and cervical cancer treatment services for eligible women an optional Medicaid coverage group created by the Breast & Cervical Cancer Prevention and Treatment Act.
- In February 2002, the Office of Inspector General (OIG) published and released audit results on End Stage Renal Disease Services performed by the AHCCCS Office of Program Integrity (OPI). The audit, part of the OIG's State Partnership Program identified nearly \$3.4 million in potential overpayments to dialysis providers and noted that AHCCCS had taken significant steps to recover overpayments and install more effective claims' edits.

ALTCS

- On October 1, 2001, initiated the first Annual Enrollment Choice transition for approximately 2,000 ALTCS members in Maricopa County.
- Effective November 1, 2001, all ALTCS EPD Program Contractors were required to use a Uniform Acuity Assessment Tool to evaluate SNF residents. The uniform tool is designed to create consistency in assessment and uniformity in level of acuity determination.

Behavioral Health

- On November 1, 2001, as part of JK settlement agreement, the first annual action plan was submitted to the plaintiff's counsel.

Waivers:

- Arizona's Health Insurance Flexibility and Accountability (HIFA) waiver was approved in December, 2001. In May 2002, AHCCCS established an interdivisional HIFA implementation team to implement the HIFA waiver by January 1, 2003.

Financial Expenditures (Title XIX)	Source	FFY Expenditures	Percentage
	Federal	2,163,509,709	64%
	State	757,277,707	23%
	Other	440,417,292	13%
	TOTAL	\$3,361,204,707	100%

Includes DSH payments and appropriations made to other State agencies.

Financial Expenditures (Title XXI)	Source	FFY Expenditures	Percentage
	Federal	58,516,647	74%
	State	20,834,857	26%
	TOTAL	\$79,351,504	100%

Administration:

- Number of FTEs = 1,341
- The first Sunset Audit on the AHCCCS' program completed by the Arizona Auditor General found that the agency has met its overall objective and purpose.

Year Twenty-One (October 1, 2002 - September 30, 2003)

Enrollment: 925,345 acute care members (498,485 TANF & TANF/MAO, 103,893 SSI & SSI/MAO, 106,800 AHCCCS Care, 3,963 MED, 50,705 KidsCare, 71,471 SOBRA Children, 8,794 SOBRA Women, 6,950 Family Planning Services, 34 Breast and Cervical Cancer, 0 State Emergency Service, 62,576 Federal Emergency Service, and 904 QMB Only), 38,092 **ALTCS** members. 11,250 persons were enrolled in **Healthcare Group**.

Program:

- In January 2003, eligibility was established for parents of SCHIP children with income up to 100% FPL.
- A new interactive interviewing eligibility system, AHCCCS Customer Eligibility (ACE), was rolled out for the ALTCS population.

Acute Care

- Commenced and completed the Request for Proposal process for the Acute Care program contract effective October 1, 2003 through September 30, 2006.
- Revised Acute Care, Children's Rehabilitative Services and Children's Medical and Dental Health contract language to adhere to the Balanced Budget Act.

ALTCS

- Revised ALTCS EPD and DDD contract language to adhere to Balanced Budget Act.

Behavioral Health

- On November 1, 2001, as part of JK settlement agreement, the first annual action plan was submitted to the plaintiff's counsel.

Waivers:

- No waivers were submitted.
- The Operational Protocol for the HIFA waiver was submitted in 2003.

Financial Expenditures (Title XIX)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	3,109,669,475	70%
	State	928,285,934	21%
	Other	388,171,070	9%
	TOTAL	\$4,426,126,479	100%

Includes DSH payments and appropriations made to other State agencies.

Financial Expenditures (Title XXI)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	186,652,834	77%
	State	55,494,867	23%
	TOTAL	\$242,147,701	100%

Administration:

- Number of FTEs = 1,538 (includes 233 positions resulting from the Prop 204 expansion of eligibility)
- During the fiscal year, the number of FTEs was reduced to 1,473

Year Twenty-Two (October 1, 2003 - September 30, 2004)

Enrollment: 986,979 **acute care** members (531,585 TANF & TANF/MAO, 111,792 SSI & SSI/MAO, 113,411 AHCCCS Care, 3,966 MED, 48,169 KidsCare, 75,409 SOBRA Children, 9,257 SOBRA Women, 7,313 Family Planning Services, 84 Breast and Cervical Cancer, 73,163 Federal Emergency Service and 1,144 QMB Only); 39,987 **ALTCS** members; 11,734 **Healthcare Group** members.

Program:

Acute Care

- Premiums were imposed for KidsCare enrollees with household income between 100% and 150% FPL on July 1, 2004.

ALTCS

- ALTCS EPD and DDD contract language was revised to adhere to the Balanced Budget Act.

Behavioral Health

- On July 1, 2004, ADHS awarded the Maricopa County Regional Behavioral Health Contract to ValueOptions. The remaining geographic service area contracts are in the RFP process for new contracts to be awarded for the CYE 2006.

Waivers:

- No new waivers were approved.

Financial Expenditures (Title XIX)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	3,603,089,958	70%
	State	1,232,292,347	24%
	Other	<u>287,042,908</u>	<u>6%</u>
	TOTAL	\$5,122,425,213	100%

Includes DSH payments and appropriations made to other State agencies.

Financial Expenditures (Title XXI)	<u>Source</u>	<u>FFY Expenditures</u>	<u>Percentage</u>
	Federal	258,894,945	77%
	State	<u>76,936,305</u>	<u>23%</u>
	TOTAL	\$335,831,250	100%

Administration:

- Number of FTEs = 1,472.7 (includes 202 positions resulting from the Prop 204 expansion of eligibility)